



**TEXAS**  
Health and Human  
Services

**Texas Health and Human Services Commission**

**Cecile Erwin Young**  
Executive Commissioner

August 16, 2021

Dan Tsai  
Deputy Administrator and Director  
Center for Medicaid & CHIP Services (CMCS)  
7500 Security Blvd  
Baltimore, MD 21244

Dear Mr. Tsai,

The Texas Health and Human Services Commission has received your letter dated August 13, 2021. We understand this letter is intended to comply with the court's August 12, 2021, Order to Clarify Sanctions Standards in *State of Texas v. Brooks-LaSure*.

In its August 12 order, the court gave the Centers for Medicare & Medicaid Services (CMS) two options:

- (1) withdraw or modify the representations by Judith Cash and others that CMS is treating the Demonstration Project as in effect, or
- (2) conform its conduct to the Demonstration Project's special terms and conditions (STCs) by either:
  - a. notifying the state that CMS intends to issue a formal decision within 20 days approving the relevant state-directed payment programs (SDPs); or
  - b. notifying the state why CMS does not anticipate approving the SDPs and notifying the state of specific further modifications required for approval, with that notice triggering the timing requirements of paragraph 34 for meeting to discuss those further modifications.

Dan Tsai  
August 16, 2021  
Page 2

We also understand CMS filed notice with the court claiming compliance with the court's order, specifically with option 2.

The state is pleased to begin the dialogue required by the STCs in the January 15 waiver extension. However, your letter does not provide enough information for HHSC to choose between the two options it contains. Specifically, you state that "CMS cannot approve Texas's proposed SDPs in their current form." But the letter does not, as the court required, describe the "specific further modifications required for approval" as required by the court's order.

Your letter provides two options for "modifications." In the first, CMS offers approval of two programs, one of which the state did not propose for state fiscal year 2022 and is inconsistent with the structure of the January 15 waiver extension. This is not a "modification" of the SDP proposals that have been existing since March. It appears, instead, to ask the state to agree to revert to the version of the section 1115 waiver that is currently set to expire in September 2022.

Under your second option, CMS seems to suggest that it will continue the January 15 waiver extension, but the state must "modify" the proposed SDPs by withdrawing them completely and starting over in a manner that is inconsistent with that waiver extension. The only concrete problem that the letter cites is the size of the SDPs. But the size of the SDPs has been known to CMS for months and is fully integrated into the January 15 waiver extension itself because it drives the budget neutrality baseline around which the waiver is built. If these were problems all along, the January 15 STCs obligated CMS to forthrightly state as much and to suggest potential solutions in good faith. CMS's failure to do so until now has seriously impeded HHSC's ability to implement the programs envisioned by the January 15 waiver extension.

Texas wants to work with CMS toward approval of our SDPs and is committed to finding an approach that is consistent with all applicable regulatory and statutory requirements. But we lack sufficient information to do so at the present time. In the appendix to your letter, Option 2 would require the state to submit new proposals that address five issues. However, CMS does not provide an explanation of how each program fails to meet each requirement of law. To ensure productive conversations, we ask CMS to specify which issues apply to which programs and to


Dan Tsai  
August 16, 2021  
Page 3

be prepared to discuss the specific modifications to each program that are required for approval.

We look forward to beginning regular meetings, by phone or in person, to resolve CMS's concerns. Texas staff are available to begin our regular meetings immediately. Please confirm CMS's availability and the CMS staff that will attend the meeting.

If you have any questions, please contact me at (512) 538-5335.

Sincerely,



Stephanie Stephens  
State Medicaid Director

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, Maryland 21244-1850



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August 13, 2021

Stephanie Stephens  
State Medicaid Director  
Texas Health and Human Services Commission  
4900 Lamar Boulevard  
MC: H100  
P.O. Box 13247  
Austin, Texas 78751

Dear Ms. Stephens:

Thank you for your commitment to the safety net and to providers that serve individuals and families enrolled in Texas' Medicaid program. I appreciate our ongoing conversations about this issue. .

As outlined in the special terms and conditions (STC) of the Texas Healthcare Transformation and Quality Improvement Program (THTQIP) section 1115(a) demonstration, Texas' DSRIP program (\$2.49B this year) is set to expire on September 30, 2021. Texas has also proposed new and expanded state directed payments (SDPs) through its managed care plans of \$3.2B per year, to begin on September 1, 2021. These SDPs are in addition to the \$3.7B per year of SDPs currently in place and subject to reapproval. In total, Texas' proposed and existing SDPs would total approximately \$7B annually, or almost a quarter of Texas' \$28.5B in annual Medicaid expenditures through managed care.

CMS is committed to working with states to support safety net providers and to ensure that safety net financing and reimbursement approaches advance measurement and accountability for improving health equity and quality. We are also committed to following all applicable federal statutory and regulatory requirements.

As part of its standard review and oversight of the state Medicaid program, CMS has been reviewing and engaging in ongoing conversations with Texas Medicaid staff on the Texas proposals for SDPs for the rating period to begin September 1, 2021. These proposals include both new SDPs and SDPs that the state is currently making and which must be renewed by September 1, subject to CMS approval, as authorized in Medicaid managed care regulations in 42 CFR 438.6(c). At this time, CMS cannot approve Texas's proposed SDPs in their current form because we are unable to establish that the proposed payments meet all applicable federal statutory and regulatory requirements under the Social Security Act (the Act) and implementing regulations. In order to permit further consideration of approval for these payments Texas must work with CMS to make the modifications explained in the attached Appendix. Among other issues set out in the Appendix, we are concerned that:



Page 2 - Stephanie Stephens

- 1) Including amounts in Managed Care Organization (MCO) capitation rates to cover the costs of the proposed new and expanded SDPs would result in managed care capitation rates not being actuarially sound in accordance with section 1903(m)(2)(A)(iii) of the Act;
- 2) The provider payments under these SDPs are not adequately tied to quality and services delivered within the contract year in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A) and (C);
- 3) The state does not have a permissible source of the non-federal share for amounts paid to MCOs to cover these higher SDPs in accordance with section 1903(w) of the Act and the implementing regulations in 42 C.F.R. part 433, subpart B.

CMS is willing to work with the state to find an approval path for your SDP proposals beginning with the modification options discussed in the attached Appendix. CMS is willing to meet with the state by phone or other means, consistent with the schedule described in the Special Terms and Conditions in the THTQIP section 1115(a) demonstration.

We recognize the importance of and share Texas's commitment to maintaining a sustainable approach to safety net hospital reimbursement. Texas has indicated that the new SDPs are intended to support safety net providers currently participating in the Texas DSRIP program, authorized under the THTQIP section 1115(a) demonstration through September 30, 2021. We recognize Texas's concern about reduced payments to safety net providers that may follow from the expiration of the DSRIP program.

To address near-term stability for safety net providers while CMS and Texas continue to work toward a more sustainable, equitable, and high quality safety net, CMS is willing to approve an amendment to the THTQIP demonstration that would extend the DSRIP program for one year (through September 30, 2022), according to the terms outlined below. Although this extension is intended to facilitate cooperation between CMS and Texas in maintaining the safety-net, it is not a part of the January demonstration project extension approval and is not subject to any conditions established in that approval.

Subject to the state's submission of an amendment request consistent with the special terms and conditions of the THTQIP demonstration, CMS is willing to approve a DSRIP extension for one year, until September 30, 2022, in an amount not to exceed the currently approved amount for the demonstration year ending September 30, 2021. Consistent with monitoring requirements for section 1115 demonstrations and our collective goal of advancing equity in the safety net, authority for the fully approved DSRIP amount would be contingent on Texas reporting on 5 to 10 metrics related to health disparities and health equity, to be agreed upon by CMS and the state. These metrics would establish a baseline for measuring health disparities in the safety net for the purposes of making future improvements around equity. CMS would propose a set of metrics, and CMS and Texas would include those metrics in the demonstration STCs that would govern the one-year extension of the DSRIP program. The metrics would include reasonable requirements for providers, managed care plans, and/or the state to track race, ethnicity, and other information about beneficiaries served, for the purposes of measuring health disparities. Reporting of metrics would be required within the demonstration year. Twenty percent of the aggregate annual DSRIP payments would be contingent on the timely and complete reporting of these metrics. Approval of the amendment would be subject

Page 3 - Stephanie Stephens

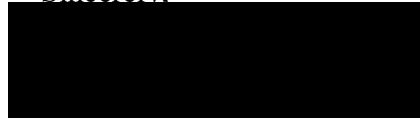
to the standard federal review process, and CMS would work with Texas to reach a decision on approval in a timely manner.

In addition, we share an interest in finding a path to long-term sustainability for the safety net. During the extension year, CMS is committed to working together in good faith with Texas to transition fully away from the DSRIP program to payments that support and advance a sustainable, high quality, equitable health safety net. This could include using a range of approaches, including approvable SDPs and other mechanisms. Such an approach will be financed jointly with federal Medicaid funds and non-federal funds that meet all federal statutory and regulatory requirements.

If Texas is interested in pursuing one of the SDP options described in the appendix, and in submitting an amendment to extend the DSRIP program as described above, for one year, CMS is available to provide technical assistance. CMS remains committed to working with Texas to ensure a high quality, sustainable health safety net.

If you have questions, please contact me or Judith Cash at (410) 786-9686.

Sincerely,



Daniel Tsai  
Deputy Administrator and Director

## **APPENDIX**

### **Options to Approve the Texas State Directed Payments**

**Option #1** – CMS approves the quality incentive payment program (QIPP) for SFY 2022 as currently submitted and consistent with the payment amounts approved in QIPP for SFY 2021. Texas will revise the comprehensive hospital increase reimbursement program (CHIRP) for SFY 2022 to reflect only the uniform hospital rate increase program (UHRIP) payment amounts that were approved in UHRIP for SFY 2021. The state will withdraw the Texas incentives for physicians and professional services (TIPPS), rural access to primary and preventative services (RAPPS), and behavioral health services directed payment program (BHS) preprints for SFY 2022.

This option is available for SFY 2022 only. The state's SDPs are evaluated every year and CMS remains concerned about issues that are broadly outlined under Option 2. Accordingly, this option does not bind CMS to conditions of approval for the state's SDPs for SFY 2023.

**Option #2** – The state modifies all five (5) state directed payment preprints currently under CMS review for SFY 2022 to be consistent with statutory and regulatory requirements. The state must submit new proposals to describe how it will address the following issues across all five (5) of the state directed payment preprints:

1. Addressing Aggregate Funding Amounts – Texas would need to demonstrate that all payment amounts are reasonable and appropriate, and that the resulting capitation payments are actuarially sound in accordance with section 1903(m)(2)(A)(iii) of the Act and 42 C.F.R. § 438.6(c)(2)(i). CMS does not consider the current aggregate funding amounts (with total proposed SDP payments amounting to almost 25% of aggregate managed care spending) to be reasonable and appropriate, and CMS is concerned that the resulting capitation rates are not actuarially sound.
2. Linking Payments to Current Utilization – Texas would need to address the reconciliation thresholds across each preprint and ensure that payments are made only for current utilization or performance measured during the rating period (rather than historical utilization or performance) in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A).
3. Addressing Concerns Related to Quality Improvement – Texas would need to ensure that any payments are based only on performance linked to Medicaid managed care enrollees (not Medicaid FFS), and performance-based payments must ensure that providers are achieving year over year improvement 42 C.F.R. § 438.6(c)(2)(ii)(C).
4. Addressing Concerns Related to the Non-Federal Share – Texas would need to affirm and document compliance with section 1903(w) of the Act and the implementing regulations in 42 C.F.R. part 433, subpart B, related to permissible sources of the non-federal share.
5. Addressing Concerns Related to the State's Evaluation Plan – Texas would need to refine the evaluation plan for each preprint to ensure that the effect of each state directed payment absent other programmatic changes or other state directed payments can be appropriately evaluated in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D). The state would need to provide consistent baseline data to demonstrate year over year changes.

**From:** [Grady, Victoria C. \(HHSC\)](#)  
**To:** [Kristian, Diona \(CMS/CMCS\)](#); [Montalbano, Kathi \(HHSC\)](#); [Bilse, Brittani \(HHSC\)](#); [Young, Gary \(HHSC\)](#); [HHSC TX Medicaid Waivers](#); [Caruthers, Courtney \(HHSC\)](#); [Roland, Dawn \(HHSC\)](#)  
**Cc:** [Greenfield, Eli S. \(CMS/CMCS\)](#); [Marunycz, Lisa \(CMS/CMCS\)](#); [Garner, Angela D. \(CMS/CMCS\)](#); [Devoid, Isaac \(CMS/CMCS\)](#); [Blunt, Ford J. \(CMS/CMCS\)](#)  
**Subject:** RE: Texas Register  
**Date:** Friday, August 27, 2021 12:24:03 PM

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Diona et al,  
Please find links to the Register PDFs for the proposals and adoptions of both the DY11 and DY12 and after rules below.

For DY11:

Proposed Rule Notice in Texas Register Published on 3/19/21:

<https://www.sos.texas.gov/texreg/pdf/backview/0319/index.shtml>

Adopted Rule Notice in Texas Register Published on 6/25/21:

<https://www.sos.texas.gov/texreg/pdf/backview/0625/index.shtml>

For DY12 and after:

Proposed Rule Notice in Texas Register Published on 5/28/21:

<https://www.sos.texas.gov/texreg/pdf/backview/0528/index.shtml>

Adopted Rule Notice in Texas Register Published on 8/20/21:

<https://www.sos.texas.gov/texreg/pdf/backview/0820/index.shtml>

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**From:** Kristian, Diona (CMS/CMCS) <Diona.Kristian@cms.hhs.gov>  
**Sent:** Friday, August 27, 2021 11:12 AM  
**To:** Montalbano, Kathi (HHSC) <Kathi.Montalbano@hhs.texas.gov>; Bilse, Brittani (HHSC) <Brittani.Bilse@hhs.texas.gov>; Young, Gary (HHSC) <gary.young@hhs.texas.gov>; Grady, Victoria C (HHSC) <Victoria.Grady@hhs.texas.gov>; HHSC TX Medicaid Waivers <TX\_Medicaid\_Waivers@hhs.texas.gov>; Caruthers, Courtney (HHSC) <Courtney.Caruthers@hhs.texas.gov>; Roland, Dawn (HHSC) <Dawn.Roland@hhs.texas.gov>  
**Cc:** Greenfield, Eli S. (CMS/CMCS) <Eli.Greenfield@cms.hhs.gov>; Marunycz, Lisa (CMS/CMCS) <Lisa.Marunycz@cms.hhs.gov>; Garner, Angela D. (CMS/CMCS) <Angela.Garner@cms.hhs.gov>; Devoid, Isaac (CMS/CMCS) <Isaac.Devoid@cms.hhs.gov>; Blunt, Ford J. (CMS/CMCS) <Ford.Blunt@cms.hhs.gov>  
**Subject:** Texas Register

**WARNING:** This email is from outside the HHS system. Do not click on links or attachments unless you expect them from the sender and know the content is safe.

Hello Texas colleagues,

On our monitoring call yesterday, we discussed the STC requirement for state rulemaking on the PHP-CCP pool. Thank you for sending the links to the Texas Administrative Code. You offered to send us the Texas Register where the rule is published. As required by STC 39, we ask that you please send us a copy of the applicable Texas Register.

Thank you,  
Diona Kristian

**From:** [Cash, Judith \(CMS/CMCS\)](#)  
**To:** [Hill, Elizabeth H. \(CMS/CMCS\)](#)  
**Subject:** FW: Texas Responses to CMS August 20 Discussion Document  
**Date:** Wednesday, September 8, 2021 3:22:59 PM  
**Attachments:** [Attachment A - CHIRP Analysis.f.xlsx](#)  
[Texas and CMS Meeting 08.20.2021 TX Responses FINAL.docx](#)  
[Attachment B - Texas Monitoring Plan Timelines.docx](#)  
[Attachment C - LPPF Information.pdf](#)

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**From:** Young, Gary (HHSC) <gary.young@hhs.texas.gov>  
**Sent:** Wednesday, August 25, 2021 4:40 PM  
**To:** Cash, Judith (CMS/CMCS) <Judith.Cash@cms.hhs.gov>; Giles, John (CMS/CMCS) <John.Giles1@cms.hhs.gov>; Snyder, Laura M. (CMS/CMCS) <Laura.Snyder1@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; Deboy, Alissa M. (CMS/CMCS) <alissa.deboy1@cms.hhs.gov>  
**Cc:** Bilse, Brittani (HHSC) <Brittani.Bilse@hhs.texas.gov>; Montalbano, Kathi (HHSC) <Kathi.Montalbano@hhs.texas.gov>; Caruthers, Courtney (HHSC) <Courtney.Caruthers@hhs.texas.gov>; HHSC TX Medicaid Waivers <TX\_Medicaid\_Waivers@hhs.texas.gov>  
**Subject:** Texas Responses to CMS August 20 Discussion Document

CMS Colleagues --

Attached for your review are the state's responses including attachments to the CMS directed payment program preprints discussion document dated August 20, 2021. Please forward to additional CMS staff as needed.

Thank you.

Gary

IP ACIA payment is > \$0  
OP ACIA payment is > \$0

Row Labels	Sum of IP ACR UPL	Sum of Total IP Medicaid Base Payments	Sum of IP UHRIP Payment	Sum of IP ACIA Payment	Sum of NAIP in UPL Test	Total Provider IP Payment Under Proposed Pre-Print	Percent of Payments to ACR for the Class
<b>Non-State-Owned IMD</b>	<b>268,080,25.41</b>	<b>31,885,381</b>	<b>10,276,422</b>	<b>-</b>	<b>-</b>	<b>42,161,804</b>	<b>15.79%</b>
Bexar	299,698,272	8,357,844	818,741	-	-	9,176,584	306%
Dallas	414,237,142	3,090,054	1,354,120	-	-	4,444,175	107%
El Paso	216,444,155	20,999	59,237	-	-	80,236	371%
Harris	954,206,128	8,957,386	3,160,037	-	-	12,117,423	127%
Lubbock	91,272,578	4,198	-	-	-	4,198	460%
MRSA Central	231,387,369	1,926,192	1,208,851	-	-	3,135,043	135%
MRSA West	285,232,636	3,126,136	1,042,688	-	-	4,168,823	146%
Tarrant	151,468,374	1,118,253	1,118,253	-	-	2,236,506	150%
Travis	151,468,374	2,526,899	-	-	-	2,678,365	241%
<b>Rural</b>	<b>556,704,067</b>	<b>7,513,101</b>	<b>2,060,666</b>	<b>-</b>	<b>-</b>	<b>9,573,767</b>	<b>17.26%</b>
Harris	180,762,910	180,806	37,676	-	-	218,482	121%
Hidalgo	528,895,569	770,199	-	-	-	770,199	146%
Jefferson	66,442,043	110,199	-	-	-	110,199	166%
Lubbock	195,047,914	1,393,895	1,655,133	-	-	3,049,027	156%
MRSA Central	70,727,512	129,787	-	-	-	152,525	216%
MRSA Northeast	52,745,585	116,049	-	-	-	116,049	220%
MRSA West	192,703,216	4,105,078	185,434	-	-	4,290,513	223%
Nueces	79,040,319	707,087	159,686	-	-	866,773	110%
<b>State-Owned IMD</b>	<b>250,438,241</b>	<b>2,256,730</b>	<b>2,337,223</b>	<b>-</b>	<b>-</b>	<b>4,593,953</b>	<b>18.93%</b>
Bexar	66,404,049	98,050	40,867	-	-	138,917	209%
Dallas	67,631,827	264,449	749,221	-	-	1,013,670	150%
MRSA Northeast	0	-	-	-	-	-	-
MRSA West	127,466,268	1,578,269	1,017,140	-	-	2,595,409	204%
Travis	486,993,836	315,962	529,995	-	-	845,957	174%
<b>State-Owned Non-IMD</b>	<b>234,977,001</b>	<b>278,015</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>278,015</b>	<b>11.89%</b>
Bexar	0	8,277	-	-	-	8,277	-
MRSA Northeast	234,977,001	269,739	-	-	-	269,739	115%
<b>Urban</b>	<b>157,659,454</b>	<b>92,821,498</b>	<b>125,165,964</b>	<b>-</b>	<b>100,184,663</b>	<b>318,172,125</b>	<b>20.2%</b>
Bexar	845,025,534	46,642,739	26,303,760	-	54,898,134	127,844,333	151%
Dallas	619,928,328	434,350	410,065	-	-	844,415	136%
Harris	660,943,804	42,541,925	97,447,011	-	45,286,530	185,275,466	280%
Jefferson	355,380,742	1,056,057	86	-	-	1,056,143	-
MRSA Central	286,035,232	136,573	128,143	-	-	264,716	8%
MRSA Northeast	148,625,099	11,599	107,443	-	-	119,042	93%
MRSA West	157,568,539	1,068,076	638,762	-	-	1,706,838	801%
Tarrant	396,012,371	722,158	-	-	-	722,158	108%
Travis	250,410,492	178,500	130,593	-	-	309,493	18%
<b>Grand Total</b>	<b>192,773,887.9</b>	<b>134,754,725</b>	<b>139,840,276</b>	<b>-</b>	<b>100,184,663</b>	<b>374,779,664</b>	<b>19.4%</b>

IP ACIA payment is > \$0  
IP ACIA payment is > \$0

Row Labels	Sum of IP ACR UPL	Sum of Total IP Medicaid Base Payments	Sum of IP UHRIP Payment	Sum of IP ACIA Payment	Sum of NAIP in UPL Test	Total Provider IP Payment Under Proposed Pre-Print	Percent of Payments to ACR for the Class
<b>Non-State-Owned IMD</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>#DIV/0!</b>
Bexar	-	-	-	-	-	-	#DIV/0!
Dallas	-	-	-	-	-	-	#DIV/0!
El Paso	-	-	-	-	-	-	#DIV/0!
Harris	-	-	-	-	-	-	#DIV/0!
Lubbock	-	-	-	-	-	-	#DIV/0!
MRSA Central	-	-	-	-	-	-	#DIV/0!
MRSA West	-	-	-	-	-	-	#DIV/0!
Tarrant	-	-	-	-	-	-	#DIV/0!
Travis	-	-	-	-	-	-	#DIV/0!
<b>Rural</b>	<b>6,936,274</b>	<b>7,123,854</b>	<b>4,616,105</b>	<b>-</b>	<b>-</b>	<b>11,739,959</b>	<b>16.9%</b>
Harris	1,126,126	806,288	697,807	-	-	1,504,094	134%
Hidalgo	605,272	865,176	291,410	-	-	1,156,586	191%
Jefferson	1,121,889	1,440,683	1,540,083	-	-	2,400,767	213%
MRSA Central	1,014,675	862,322	1,540,083	-	-	2,400,767	213%
MRSA Northeast	1,187,920	1,180,278	285,784	-	-	1,465,563	144%
MRSA West	2,075,462	627,169	229,965	-	-	857,134	456%
Nueces	374,809	2,046,979	1,154,035	-	-	3,201,013	154%
<b>State-Owned IMD</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>434,703</b>	<b>11.6%</b>
Bexar	-	-	-	-	-	-	#DIV/0!
Dallas	-	-	-	-	-	-	#DIV/0!
MRSA Northeast	-	-	-	-	-	-	#DIV/0!
MRSA West	-	-	-	-	-	-	#DIV/0!
Travis	-	-	-	-	-	-	#DIV/0!
<b>State-Owned Non-IMD</b>	<b>3,575,076</b>	<b>2,719,780</b>	<b>2,447,019</b>	<b>-</b>	<b>-</b>	<b>5,166,799</b>	<b>14.5%</b>
Bexar	3,575,076	2,719,780	2,447,019	-	-	5,166,799	145%
MRSA Northeast	57,780,154	46,491,033	44,389,607	-	-	90,880,640	157%
Bexar	35,021,758	17,832,704	21,267,830	-	-	39,100,534	112%
Dallas	19,665,868	27,894,021	22,865,410	-	-	50,759,432	258%
Jefferson	1,956,649	622,497	-	-	-	622,497	32%
Lubbock	-	-	-	-	-	-	-
MRSA Central	-	-	-	-	-	-	-
MRSA Northeast	-	-	-	-	-	-	-
MRSA West	-	-	-	-	-	-	-
Tarrant	1,105,879	141,811	-	-	-	141,811	13%

Travis	\$	68,261,504	\$	-	\$	75,118	\$	-	\$	75,118	107,787,398	#DIV/0!	158%
<b>Grand Total</b>	<b>\$</b>	<b>68,261,504</b>	<b>\$</b>	<b>-</b>	<b>\$</b>	<b>75,118</b>	<b>\$</b>	<b>-</b>	<b>\$</b>	<b>75,118</b>	<b>107,787,398</b>	<b>#DIV/0!</b>	<b>158%</b>



Yoon v. Becton Dickinson, No. 23-cv-144  
4/15/2025

418 Hospitals

Hospital Performance Metrics - Q3 2023										Patient Care & Financial Summary										Operational & Compliance Data									
Hospital ID	Hospital Name	Location	Type	Size (Beds)	Patient Care			Financial			Operational			Compliance			Patient Care & Financial Summary			Operational & Compliance Data									
					Admissions	Discharges	Readmissions	Revenue	Cost	Profit	Length of Stay	Wait Time	Staffing	Incidents	Audit Score	Accredited	Accredited	Accredited	Accredited	Accredited	Accredited	Accredited	Accredited						
001	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
002	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
003	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
004	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
005	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
006	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
007	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
008	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
009	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
010	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
011	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
012	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
013	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
014	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
015	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
016	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
017	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
018	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
019	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
020	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
021	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
022	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
023	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
024	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
025	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
026	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
027	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
028	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
029	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
030	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
031	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
032	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
033	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
034	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
035	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
036	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
037	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
038	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
039	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
040	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
041	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
042	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
043	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
044	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
045	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
046	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
047	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
048	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
049	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
050	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
051	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
052	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
053	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
054	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
055	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
056	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
057	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
058	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
059	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
060	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
061	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
062	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
063	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
064	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
065	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%							
066	St. Mary's Hospital	New York	General	250	1200	1100	5%	\$12M	\$8M	\$4M	4.5	24h</																	

Rank	Company	Revenue	Profit	Assets	Liabilities	Equity	Debt	Capital	Employees	Locations	Website	Year
1	Apple Inc.	229,670	79,120	339,600	110,000	229,600	110,000	119,600	1,000,000	125	apple.com	2020
2	Microsoft Corporation	168,200	74,400	242,600	100,000	142,600	100,000	42,600	1,200,000	175	microsoft.com	2020
3	Amazon.com, Inc.	137,100	20,800	206,000	100,000	106,000	100,000	6,000	900,000	300	amazon.com	2020
4	Facebook, Inc.	119,300	29,700	149,000	50,000	99,000	50,000	49,000	550,000	550	facebook.com	2020
5	Alphabet Inc.	110,100	28,000	138,100	50,000	88,100	50,000	38,100	700,000	700	google.com	2020
6	Netflix, Inc.	20,100	6,700	26,800	10,000	16,800	10,000	6,800	100,000	100	netflix.com	2020
7	Twitter, Inc.	5,500	1,100	6,600	2,000	4,600	2,000	2,600	30,000	30	twitter.com	2020
8	LinkedIn Corporation	4,700	1,100	5,800	2,000	3,800	2,000	1,800	20,000	20	linkedin.com	2020
9	Slack Technologies, Inc.	1,300	300	1,600	500	1,100	500	600	10,000	10	slack.com	2020
10	Zoom Video Communications, Inc.	400	100	500	200	300	200	100	5,000	5	zoom.us	2020
11	Dropbox, Inc.	2,100	500	2,600	1,000	1,600	1,000	600	15,000	15	dropbox.com	2020
12	Spotify AB	3,700	800	4,500	2,000	2,500	2,000	500	30,000	30	spotify.com	2020
13	SoundCloud	1,100	200	1,300	500	800	500	300	10,000	10	soundcloud.com	2020
14	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
15	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
16	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
17	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
18	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
19	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
20	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
21	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
22	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
23	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
24	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
25	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
26	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
27	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
28	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
29	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
30	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
31	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
32	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
33	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
34	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
35	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
36	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
37	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
38	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
39	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
40	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
41	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
42	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
43	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
44	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
45	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
46	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
47	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
48	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
49	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
50	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
51	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
52	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
53	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
54	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
55	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
56	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
57	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
58	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
59	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
60	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
61	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
62	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
63	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
64	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
65	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
66	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
67	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
68	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
69	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
70	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
71	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
72	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
73	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
74	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
75	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
76	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
77	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
78	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
79	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
80	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
81	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
82	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
83	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
84	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
85	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
86	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
87	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
88	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
89	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
90	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
91	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
92	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
93	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
94	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
95	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
96	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
97	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
98	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
99	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020
100	Bandcamp	500	100	600	200	400	200	200	5,000	5	bandcamp.com	2020

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## CHIRP - Outpatient Payment Analysis for Hospitals Only Participating in UHRIP (Comparison to ACR)

Total: 178 Hospitals													
2021 Master TPI	TPI	Master NPI	NPI	PROVIDER NAME	CHIRP Class	SDA	Combined Rates Class & SDA	OP ACR UPL	Total OP Medicaid Base Payments	OP UHRIP Payment	\$202.617.834	Total Outpatient Payment Level (UHRIP compared to ACR)	Outpatient: UHRIP Only
136141205	136141205	1821011248	1821011248	BEXAR COUNTY HOSPITAL DISTRICT-UNIVERSITY HEALTH SYSTEM	Urban State-Owned Non-IMD	Bexar	Urban Bexar State-Owned Non-IMD Harris	\$35,021,758	\$17,832,704	\$21,267,830	112%	Yes	Yes
094092602	094092602	1548226988	1548226988	UNIVERSITY OF TEXAS MEDICAL BRANCH AT GALVESTON		Harris		\$44,723,489	\$27,982,750	\$23,662,302	115%	Yes	Yes
137249208	137249208	1477516466	1477516466	SCOTT AND WHITE MEMORIAL HOSPITAL-SCOTT AND WHITE MEDICAL CENTER	Urban	MSA Central	Urban MSA Central	\$37,771,131	\$12,773,878	\$28,806,572	110%	Yes	Yes
160709501	160709501	1053317362	1053317362	TEMPLE DAY SURGERY AT RENAISSANCE LLC-DOCTORS HOSPITAL AT RENAISSANCE	Urban	Hidalgo	Urban Hidalgo	\$20,001,395	\$7,853,011	\$12,689,024	103%	Yes	Yes
133355104	133355104	1205900370	1205900370	HARRIS COUNTY HOSPITAL DISTRICT	Urban	Harris	Urban Harris	\$0	\$14,263,346	\$9,853,254	N/A	Yes	Yes
126675104	126675104	1992753222	1992753222	TARRANT COUNTY HOSPITAL DISTRICT-THE HEALTH NETWORK	Urban	Tarrant	Urban Tarrant	\$25,418,750	\$11,498,500	\$14,994,605	104%	Yes	Yes
112712802	112712802	1023065794	1023065794	CHICKA WOMANS HOSPITAL LP-TO THE WOMANS HOSPITAL OF TEXAS	Urban	Harris	Urban Harris	\$3,930,315	\$2,283,796	\$1,803,909	104%	Yes	Yes
121807504	121807504	1063466035	1063466035	CHICKA CLEAR LAKE LP-HCA HOUSTON HEALTHCARE CLEAR LAKE	Urban	Harris	Urban Harris	\$8,084,740	\$5,029,778	\$4,461,736	117%	Yes	Yes
137245009	137245009	1467442418	1467442418	NORTHWEST HEALTHCARE SYSTEM INC-NORTHWEST TEXAS-PSYC UNIT	Urban	Lubbock	Urban Lubbock	\$11,918,124	\$5,776,430	\$8,141,592	122%	Yes	Yes
020817501	020817501	1174576698	1174576698	CHICKA BAYSHORE LP-HCA HOUSTON HEALTHCARE SOUTHEAST	Urban	Harris	Urban Harris	\$9,328,680	\$7,601,949	\$7,020,520	157%	Yes	Yes
112742302	112742302	1811942238	1811942238	KINGWOOD PLAZA HOSPITAL-HCA HOUSTON HEALTHCARE KINGWOOD	Urban	Harris	Urban Harris	\$9,769,971	\$5,375,676	\$5,188,535	108%	Yes	Yes
115254004	115254004	1164526786	1164526786	SETON FAMILY OF HOSPITALS-SETON MEDICAL CENTER AUSTIN	Urban	Texas	Urban Texas	\$4,239,819	\$1,479,481	\$3,525,208	118%	Yes	Yes
020841501	020841501	1962455816	1962455816	CHICKA CONROE LP-HCA HOUSTON HEALTHCARE CONROE	Urban	Harris	Urban Harris	\$6,350,086	\$3,622,589	\$3,578,422	113%	Yes	Yes
094187402	094187402	1275580938	1275580938	CHICKA WEST HOUSTON LP-HCA HOUSTON HEALTHCARE WEST	Urban	Harris	Urban Harris	\$6,118,135	\$3,659,625	\$3,131,112	111%	Yes	Yes
112679902	112679902	1205833985	1205833985	MISSION HOSPITAL INC-MISSION REGIONAL MEDICAL CENTER	Urban	Hidalgo	Urban Hidalgo	\$6,291,029	\$4,197,647	\$3,813,229	127%	Yes	Yes
314080801	314080801	1033120423	1033120423	TEXAS HEALTH HUGULEY INC-TEXAS HEALTH HUGULEY FORT WORTH SOUTH	Urban	Tarrant	Urban Tarrant	\$4,602,302	\$2,251,520	\$3,475,241	124%	Yes	Yes
194997601	194997601	1851390967	1851390967	UHS OF TEXOMA INC-REBA MCENTIRE CENTER FOR REHABILITATION	Urban	MSA Northeast	Urban MSA Northeast	\$5,912,105	\$1,402,661	\$4,844,059	106%	Yes	Yes
326725404	326725404	1265772362	1265772362	SCOTT AND WHITE HOSPITAL COLLEGE STATION-BAYLOR SCOTT & WHITE MEDICAL CENTER COLLEGE STATION	Urban	MSA Central	Urban MSA Central	\$3,249,952	\$1,517,411	\$3,718,619	161%	Yes	Yes
377705401	377705401	1750819025	1750819025	NORTH HOUSTON TRMC LLC-TOMBALL REGIONAL MEDICAL CENTER	Urban	Harris	Urban Harris	\$1,998,885	\$1,139,758	\$1,289,766	122%	Yes	Yes
138411709	138411709	1720088123	1720088123	GUADALUPE COUNTY HOSPITAL BOARD-GUADALUPE REGIONAL MEDICAL CENTER	Urban	Bexar	Urban Bexar	\$2,059,297	\$1,166,876	\$2,113,869	159%	Yes	Yes
137907508	137907508	1124052162	1124052162	CITIZENS MEDICAL CENTER COUNTY OF VICTORIA-CITIZENS MEDICAL CENTER	Urban	Nueces	Urban Nueces	\$2,944,390	\$1,196,156	\$1,950,379	107%	Yes	Yes
158980601	158980601	1124137054	1124137054	BRIM HEALTHCARE OF TEXAS LLC-WADLEY REGIONAL MEDICAL CENTER	Urban	Texas	Urban Texas	\$2,097,273	\$2,400,789	\$1,661,458	115%	Yes	Yes
094106401	094106401	1578780870	1578780870	CEADAR PARK REGIONAL MEDICAL CENTER	Urban	Texas	Urban Texas	\$2,593,024	\$779,618	\$1,814,142	100%	Yes	Yes
190123303	190123303	1265568638	1265568638	SCOTT AND WHITE HOSPITAL ROUND ROCK-BAYLOR SCOTT & WHITE MEDICAL CENTER - ROUND ROCK	Urban	Texas	Urban Texas	\$4,131,774	\$1,356,587	\$2,977,606	105%	Yes	Yes
112671602	112671602	1972581940	1972581940	COMMUNITY HOSPITAL OF BRAZOSPORT-BRAZOSPORT REGIONAL HEALTH SYSTEM	Urban	Harris	Urban Harris	\$1,988,217	\$1,266,379	\$927,485	110%	Yes	Yes
127728304	127728304	1417941295	1417941295	UNIVERSITY OF TEXAS HEALTH AND SCIENCE CENTER AT TYLER	State-Owned Non-IMD	MSA Northeast	State-Owned Non-IMD MSA Northeast	\$3,575,076	\$2,719,780	\$2,447,019	145%	Yes	Yes
207311601	207311601	1114903523	1114903523	BRIM HEALTHCARE OF TEXAS LLC-WADLEY REGIONAL MEDICAL CENTER	Urban	MSA Northeast	Urban MSA Northeast	\$1,394,358	\$409,508	\$1,276,690	121%	Yes	Yes
020977201	020977201	1376662296	1376662296	CEADAR PARK REGIONAL MEDICAL CENTER	Urban	Texas	Urban Texas	\$1,666,894	\$401,120	\$1,734,418	128%	Yes	Yes
020977701	020977701	1134166192	1134166192	ORTHOPEDIC HOSPITAL LTD-TEXAS ORTHOPEDIC HOSPITAL	Urban	Harris	Urban Harris	\$1,181,308	\$698,948	\$731,535	121%	Yes	Yes
412747401	412747401	1245878990	1144225699	WALKER COUNTY HOSPITAL CORPORATION-HUNTSVILLE MEMORIAL HOSPITAL	Urban	Jefferson	Urban Jefferson	\$1,956,649	\$622,497	\$-	32%	Yes	Yes
366812101	366812101	1033568621	1033568621	CHRISTUS HOPKINS HEALTH ALLIANCE-CHRISTUS MOTHER FRANCES HOSPITAL - SULPHUR SPRINGS	Rural	MSA Northeast	Rural MSA Northeast	\$2,677,227	\$1,820,410	\$1,052,381	107%	Yes	Yes
349059101	349059101	1871917971	1871917971	SAN ANTONIO BEHAVIORAL HEALTHCARE HOSPITAL, LLC-	Non-State-Owned	Bexar	Non-State-Owned IMD Bexar	\$0	\$0	\$-	N/A	Yes	Yes
121829905	121829905	1598764359	1598764359	WEST OAK HOSPITAL INC-TEXAS WEST OAKS HOSPITAL	Non-State-Owned	Harris	Non-State-Owned IMD Harris	\$0	\$0	\$-	N/A	Yes	Yes
191968001	191968001	1386779304	1386779304	UNIVERSITY BEHAVIORAL HEALTH OF EL PASO LLC	IMD	El Paso	Non-State-Owned IMD El Paso	\$0	\$0	\$-	N/A	Yes	Yes
337433201	337433201	1710985098	1710985098	TIRR MEMORIAL HERMANN	Non-State-Owned	Harris	Non-State-Owned IMD Harris	\$0	\$0	\$-	N/A	Yes	Yes
361635101	361635101	1003282039	1003282039	SUN HOUSTON, LLC- Clarkey Child Guidance Center 8535 Tom Sick Drive San Antonio, TX 78229	IMD	Harris	Non-State-Owned IMD Harris	\$0	\$0	\$-	N/A	Yes	Yes
112742503	112742503	1326015595	1326015595	DALLAS BEHAVIORAL HEALTHCARE HOSPITAL LLC-	Non-state-owned	Bexar	Non-state-owned IMD Bexar	\$0	\$0	\$-	N/A	Yes	Yes
333289201	333289201	1457791105	1457791105	HEALTHCARE PARTNERS	IMD	Dallas	Non-State-Owned IMD Dallas	\$0	\$0	\$-	N/A	Yes	Yes
175965601	175965601	1861598633	1861598633	SHC KPH LP-KINGWOOD PINES HOSPITAL	IMD	Harris	Non-State-Owned IMD Harris	\$0	\$0	\$-	N/A	Yes	Yes
021196301	021196301	124534472	124534472	TXODSHS dba North Texas State Hospital-Vernon	State-Owned IMD	MSA West	State-Owned IMD MSA West	\$0	\$0	\$-	N/A	Yes	Yes
021240902	021240902	1043280951	1043280951	TEXAS LAUREL RIDGE HOSPITAL LP-LAUREL RIDGE TREATMENT CENTER	Non-State-Owned	Bexar	Non-State-Owned IMD Bexar	\$0	\$0	\$-	N/A	Yes	Yes
1922078815	1922078815			GLEN OAKS HOSPITAL INC-GLEN OAKS HOSPITAL	IMD	Dallas	Non-State-Owned IMD Dallas	\$0	\$0	\$-	N/A	Yes	Yes
1730187568	1730187568			CYPRESS CREEK HOSPITAL INC	Non-State-Owned	Harris	Non-State-Owned IMD Harris	\$0	\$0	\$-	N/A	Yes	Yes
1760567085	1760567085			STARR COUNTY MEMORIAL HOSPITAL	IMD	Harris	Non-State-Owned IMD Harris	\$0	\$0	\$-	N/A	Yes	Yes
1821061532	1821061532			HEALTHSOUTH REHABILITATION-ENCORPASS HEALTH REHABILITATION HOSPITAL OF MIDLA	Rural	Hidalgo	Rural Hidalgo	\$605,272	\$865,176	\$291,410	191%	Yes	Yes
1578809505	1578809505			TEXAS OAKS PSYCHIATRIC HOSPITAL LP-AUSTIN OAKS HOSPITAL	Urban	MSA West	Urban MSA West	\$0	\$0	\$-	N/A	Yes	Yes
1093021719	1093021719			BEHAVIORAL HEALTH MANAGEMENT, LLC-	Non-State-Owned	Travis	Non-State-Owned IMD Travis	\$0	\$0	\$-	N/A	Yes	Yes
1154782548	1154782548			STRATEGIC BH-BROWNSVILLE, LLC-PALMS BEHAVIORAL HEALTH	IMD	Harris	Non-State-Owned IMD Harris	\$0	\$0	\$-	N/A	Yes	Yes
1680908790	1680908790			HOUSTON BEHAVIORAL HEALTHCARE HOSPITAL, LLC-	Urban	Hidalgo	Non-State-Owned IMD Hidalgo	\$0	\$0	\$-	N/A	Yes	Yes
154823265	154823265			HEALTHSOUTH REHAB INSTITUTE OF SAN ANTONIO RIO-SAN ENCOMPASS HEALTH REHABILITATION HOSPITAL OF SAN AN	IMD	Harris	Non-State-Owned IMD Harris	\$0	\$0	\$-	N/A	Yes	Yes
1689692402	1689692402			HMH CEDAR CREST LLC-CEDAR CREST HOSPITAL	Non-State-Owned	Hidalgo	Non-State-Owned IMD Hidalgo	\$0	\$0	\$-	N/A	Yes	Yes
021215104	021215104			CEADAR CREST LLC-CEDAR CREST HOSPITAL	IMD	Harris	Non-State-Owned IMD Harris	\$0	\$0	\$-	N/A	Yes	Yes

313188001	313188001	1659539567	1659539567	HEALTHSOUTH REHABILITATION HOSPITAL OF ABILENE	Urban	Non-State-Owned	Urban	MSA West	Urban MSA West	\$0	\$0	\$0	N/A	Yes
184076101	184076101	1205999232	1205999232	HICKORY TRAIL HOSPITAL LP	Urban	Non-State-Owned	Urban	Dallas	Non-State-Owned JMD	\$0	\$0	\$0	N/A	Yes
197063401	197063401	1841497153	1841497153	GPHC LLC-GOLDEN PLAINS COMMUNITY HOSPITAL	Rural	Non-State-Owned	Rural	Lubbock	Rural Lubbock	\$549,451	\$425,619	\$67,480	20%	Yes
127298107	127298107	1174568779	1174568779	ANDREWS COUNTY HOSPITAL DISTRICT	Rural	Non-State-Owned	Rural	MSA West	Rural MSA West	\$302,448	\$307,473	\$184,166	163%	Yes
132344705	132344705	1275581852	1275581852	ROLLING PLAINS MEMORIAL HOSPITAL	Rural	Non-State-Owned	Rural	MSA West	Rural MSA West	\$518,544	\$321,960	\$210,386	103%	Yes
286326801	286326801	1154612638	1154612638	SETON FAMILY OF HOSPITALS-SETON SMITHVILLE REGIONAL HOSPITAL	Urban	Non-State-Owned	Urban	Travis	Urban Travis	\$439,458	\$150,439	\$611,536	173%	Yes
344854001	344854001	1215354899	1215354899	WESTPARK SPRINGS LLC-CLINTON	Non-State-Owned	Non-State-Owned	Non-State-Owned	Harris	Non-State-Owned JMD	\$0	\$0	\$0	N/A	Yes
133544006	133544006	1568454003	1568454003	WESTPARK SMITH COUNTY HOSPITAL DISTRICT-THEREFORD REGIONAL MEDICAL CENTER	Rural	Non-State-Owned	Rural	Lubbock	Rural Lubbock	\$448,545	\$373,723	\$743,261	249%	Yes
021195501	021195501	1477669208	1477669208	Texas HMSC North Texas State Hospital-Wichita	State-Owned	State-Owned	State-Owned	MSA West	State-Owned JMD MSA	\$0	\$0	\$0	N/A	Yes
177658501	177658501	1851346407	1851346407	UHP LP	JMD	Non-State-Owned	JMD	Tarrant	Non-State-Owned JMD	\$0	\$0	\$0	N/A	Yes
112745802	112745802	1518937218	1518937218	RIVER CREST HOSPITAL	JMD	Non-State-Owned	JMD	MSA West	Non-State-Owned JMD	\$0	\$0	\$0	N/A	Yes
136330112	136330112	1578588463	1578588463	SCURRY COUNTY HOSPITAL DISTRICT-D.M. COGDELL MEMORIAL HOSPITAL	Rural	Non-State-Owned	Rural	MSA West	Rural MSA West	\$449,139	\$427,231	\$232,458	147%	Yes
094121303	094121303	1821025990	1821025990	MEMORIAL HOSPITAL	Rural	Non-State-Owned	Rural	MSA West	Rural MSA West	\$0	\$299,245	\$155,662	N/A	Yes
137909111	137909111	1689630865	1689630865	MEMORIAL MEDICAL CENTER	Urban	Non-State-Owned	Urban	Nueces	Rural Nueces	\$374,809	\$291,018	\$143,685	116%	Yes
220238402	220238402	1043457583	1043457583	MEMORIAL HERMANN REHABILITATION HOSPITAL KATY-	Urban	Non-State-Owned	Urban	Harris	Urban Harris	\$0	\$0	\$195,964	N/A	Yes
112751605	112751605	1720094550	1720094550	Texas Department of State Health Services dba El Paso Psychiatric Center	State-Owned	State-Owned	State-Owned	El Paso	State-Owned JMD El Paso	\$0	\$0	\$0	N/A	Yes
021194801	021194801	1326052226	1326052226	GEORGETOWN BEHAVIORAL HEALTH INSTITUTE, LLC-GEORGETOWN	JMD	Non-State-Owned	JMD	Travis	State-Owned JMD Travis	\$0	\$0	\$0	N/A	Yes
345305201	345305201	1275956807	1275956807	BEHAVIORAL HEALTH INSTITUTE LLC	JMD	Non-State-Owned	JMD	Travis	Non-State-Owned JMD	\$0	\$0	\$0	N/A	Yes
396650901	396650901	1972071991	1972071991	GAINESVILLE COMMUNITY HOSPITAL, INC.-NORTH TEXAS MEDICAL CENTER	Rural	Non-State-Owned	Rural	MSA Northeast	Rural MSA Northeast	\$735,874	\$428,615	\$328,507	103%	Yes
137919003	137919003	1992713119	1992713119	Texas Department of State Health Services dba Terrell State Hospital	State-Owned	State-Owned	State-Owned	Dallas	State-Owned JMD Dallas	\$0	\$0	\$0	N/A	Yes
348183001	348183001	1144625153	1144625153	AUSTIN BEHAVIORAL HOSPITAL LLC-CROSS CREEK HOSPITAL	JMD	Non-State-Owned	JMD	Travis	Non-State-Owned JMD	\$0	\$0	\$0	N/A	Yes
140714001	140714001	1861487779	1861487779	LIMESTONE MEDICAL CENTER	Rural	Non-State-Owned	Rural	MSA Central	Rural MSA Central	\$582,470	\$558,332	\$135,245	119%	Yes
311054601	311054601	1003192311	1003192311	EL CAMPO MEMORIAL HOSPITAL-	Rural	Non-State-Owned	Rural	Harris	Rural Harris	\$605,828	\$398,633	\$289,301	114%	Yes
094347402	094347402	1144294893	1144294893	HEALTHSOUTH PLANO REHABILITATION HOSPITAL LLC-HEALTHSOUTH PLANO REHABILITATION HOSPITAL	Urban	Non-State-Owned	Urban	Dallas	Urban Dallas	\$0	\$0	\$0	N/A	Yes
333366801	333366801	1750620456	1750620456	OCEANS BEHAVIORAL HOSPITAL OF ABILENE LLC-	JMD	Non-State-Owned	JMD	MSA West	Non-State-Owned JMD	\$0	\$0	\$0	N/A	Yes
336658501	336658501	1396184180	1396184180	BEHAVIORAL HEALTH CENTER OF THE PERMIAN BASIN LLC-OCEANS	JMD	Non-State-Owned	JMD	MSA West	Non-State-Owned JMD	\$0	\$0	\$0	N/A	Yes
112684904	112684904	1831170273	1831170273	REEVES COUNTY HOSPITAL DISTRICT	Rural	Non-State-Owned	Rural	MSA West	Rural MSA West	\$91,961	\$99,069	\$6,036	212%	Yes
391364401	391364401	1740791748	1740791748	WOODLAND SPRINGS LLC-WOODLAND SPRINGS	Urban	Non-State-Owned	Urban	Harris	Non-State-Owned JMD	\$0	\$0	\$0	N/A	Yes
189947801	189947801	1314108053	1314108053	DANFORTH COUNTY HOSPITAL DISTRICT-MEDICAL ARTS HOSPITAL	Rural	Non-State-Owned	Rural	MSA West	Rural MSA West	\$413,418	\$446,555	\$166,137	148%	Yes
314562501	314562501	1982920773	1982920773	HEALTHSOUTH REHABILITATION HOSPITAL OF DALLAS	Urban	Non-State-Owned	Urban	Dallas	Urban Dallas	\$0	\$0	\$0	N/A	Yes
391576104	391576104	1144435260	1144435260	CROCKETT MEDICAL CENTER LLC-CROCKETT MEDICAL CENTER	Rural	Non-State-Owned	Rural	MSA Northeast	Rural MSA Northeast	\$0	\$442,350	\$92,546	N/A	Yes
209190201	209190201	1245422567	1245422567	HEALTHSOUTH REHABILITATION HOSPITAL OF ROUND ROCK	Urban	Non-State-Owned	Urban	Travis	Urban Travis	\$0	\$0	\$0	N/A	Yes
137074409	137074409	1689505921	1689505921	EASTLAND MEMORIAL HOSPITAL DISTRICT-EASTLAND MEMORIAL HOSPITAL	Rural	Non-State-Owned	Rural	MSA West	Rural MSA West	\$316,722	\$408,930	\$182,870	187%	Yes
210433301	210433301	1427048743	1427048743	RED RIVER HOSPITAL LLC-RED RIVER HOSPITAL	JMD	Non-State-Owned	JMD	MSA West	Non-State-Owned JMD	\$0	\$0	\$0	N/A	Yes
395486901	395486901	1346729159	1346729159	BAYLOR SCOTT & WHITE MEDICAL CENTERS - CAPITOL ARE BAYLOR SCOTT & WHITE MEDICAL CENTER - PFLUGERVILLE	Urban	Non-State-Owned	Urban	Travis	Urban Travis	\$271,137	\$131,875	\$358,683	181%	Yes
020988401	020988401	1023011657	1023011657	SWEENEY COMMUNITY HOSPITAL	Rural	Non-State-Owned	Rural	Harris	Rural Harris	\$472,278	\$370,230	\$358,280	154%	Yes
309464801	309464801	1548546088	1548546088	HEALTHSOUTH REHAB HOSPITAL OF SOUTH AUSTIN LLC-HEALTHSOUTH	Urban	Non-State-Owned	Urban	Travis	Urban Travis	\$0	\$0	\$0	N/A	Yes
32081601	32081601	1760417646	1760417646	FANNIN COUNTY HOSPITAL AUTHORITY-TMC BONHAM HOSPITAL	Rural	Non-State-Owned	Rural	MSA Northeast	Rural MSA Northeast	\$382,988	\$218,003	\$215,590	113%	Yes
136331910	136331910	1720096019	1720096019	COUNTY OF WARD-WARD MEMORIAL HOSPITAL	Rural	Non-State-Owned	Rural	MSA West	Rural MSA West	\$226,598	\$206,887	\$64,498	120%	Yes
368423501	368423501	1932573417	1932573417	ST JOSEPH HEALTHSOUTH REHABILITATION HOSPITAL LLC-CHI ST JOSEPH	Urban	Non-State-Owned	Urban	MSA Central	Urban MSA Central	\$0	\$0	\$0	N/A	Yes
121808305	121808305	1124061882	1124061882	JACKSON COUNTY HOSPITAL DISTRICT-JACKSON HEALTHCARE CENTER	Rural	Non-State-Owned	Rural	MSA Central	Rural MSA Central	\$238,613	\$274,287	\$91,427	153%	Yes
119874904	119874904	1790777696	1790777696	JACK COUNTY HOSPITAL DISTRICT-FATH COMMUNITY HOSPITAL	Rural	Non-State-Owned	Rural	MSA West	Rural MSA West	\$113,682	\$171,142	\$115,522	252%	Yes
389645801	389645801	1174021695	1174021695	REHABILITATION HOSPITAL LLC-UT HEALTH EAST TEXAS REHABILITATION HOSPITAL	Urban	Non-State-Owned	Urban	MSA Northeast	Urban MSA Northeast	\$0	\$0	\$180,328	N/A	Yes
130826407	130826407	1639176456	1639176456	COON MEMORIAL HOSPITAL	Rural	Non-State-Owned	Rural	MSA West	Non-State-Owned JMD	\$199,703	\$157,912	\$97,295	128%	Yes
136492909	136492909	1265648513	1265648513	LUBBOCK REGIONAL MHMR CENTER	JMD	Non-State-Owned	JMD	Lubbock	Non-State-Owned JMD	\$0	\$0	\$0	N/A	Yes
094353202	094353202	1467453902	1467453902	CHRISTUS HEALTH ARK TEXAS-CHRISTUS ST MICHAEL REHABILITATION HOSPITAL	Urban	Non-State-Owned	Urban	MSA Northeast	Urban MSA Northeast	\$0	\$0	\$106,170	N/A	Yes
135040099	135040099	1871583153	1871583153	ELECTRA HOSPITAL DISTRICT-ELECTRA MEMORIAL HOSPITAL	Rural	Non-State-Owned	Rural	MSA West	Rural MSA West	\$295,031	\$279,235	\$72,802	119%	Yes
316360201	316360201	1407121189	1407121189	AL LEASING COLEMAN INC-COLEMAN COUNTY MEDICAL CENTER COMPANY	Rural	Non-State-Owned	Rural	MSA West	Rural MSA West	\$164,728	\$115,539	\$15,226	101%	Yes
138706004	138706004	1972511921	1972511921	Texas Department of State Health Services dba San Antonio State Hospital	State-Owned	State-Owned	State-Owned	Bexar	State-Owned JMD Bexar	\$0	\$0	\$0	N/A	Yes
284333604	284333604	1154329952	1154329952	LIBERTY COUNTY HOSPITAL DISTRICT NO 1-LIBERTY COUNTY REGIONAL MEDICAL CENTER	Rural	Non-State-Owned	Rural	Jefferson	Rural Jefferson	\$236,353	\$172,832	\$119,798	124%	Yes
220798701	220798701	1326349986	1326349986	SCOTT AND WHITE HOSPITAL - LLANO-BAYLOR SCOTT AND WHITE MEDICAL CENTER - LLANO	Rural	Non-State-Owned	Rural	MSA Central	Rural MSA Central	\$0	\$144,503	\$7,549	N/A	Yes
021224301	021224301	1831140698	1831140698	GREEN OAKS HOSPITAL SUBSIDIA	JMD	Non-State-Owned	JMD	Dallas	Non-State-Owned JMD	\$0	\$0	\$0	N/A	Yes
020994001	020994001	1174522494	1174522494	BAYSIDE COMMUNITY HOSPITAL-	Rural	Non-State-Owned	Rural	Jefferson	Rural Jefferson	\$93,509	\$179,462	\$109,667	309%	Yes
136325111	136325111	1184631673	1184631673	MITCHELL COUNTY HOSPITAL DISTRICT-MITCHELL COUNTY HOSPITAL	Rural	Non-State-Owned	Rural	MSA West	Rural MSA West	\$32,002	\$32,619	\$15,015	121%	Yes
12667806	12667806	1104842475	1104842475	W J MANGOLD MEMORIAL HOSPITAL	Rural	Non-State-Owned	Rural	Lubbock	Rural Lubbock	\$125,553	\$76,148	\$151,523	181%	Yes
083290905	083290905	1477857332	1477857332	BELLEVILLE ST JOSEPH HEALTH CENTER	Rural	Non-State-Owned	Rural	Harris	Rural Harris	\$316,826	\$203,723	\$147,847	111%	Yes
121692107	121692107	1861510521	1861510521	HARDENMAN COUNTY MEMORIAL HOSPITAL	Rural	Non-State-Owned	Rural	MSA West	Rural MSA West	\$222,309	\$215,104	\$78,521	132%	Yes
200883501	200883501	1932378856	1932378856	REFUGER HOSPITAL LEASING HERMILL INC-SABINE COUNTY HOSPITAL	Rural	Non-State-Owned	Rural	MSA Northeast	Rural MSA Northeast	\$163,470	\$147,950	\$119,435	164%	Yes
130734007	130734007	1578547345	1578547345	MEMORIAL MEDICAL CENTER SAN AUGUSTINE	Rural	Non-State-Owned	Rural	MSA Northeast	Rural MSA Northeast	\$12,234	\$368	\$1,234	30%	Yes
316076401	316076401	1518253194	1518253194	SWISHER MEMORIAL HEALTHCARE SYSTEM-SWISHER MEMORIAL HOSPITAL	Rural	Non-State-Owned	Rural	Lubbock	Rural Lubbock	\$173,078	\$126,354	\$155,603	163%	Yes
121060201	121060201	1205164928	1205164928	CAHMC LLC-RICE MEDICAL CENTER	Rural	Non-State-Owned	Rural	MSA Central	Rural MSA Central	\$108,490	\$123,279	\$23,622	135%	Yes



148698701	148698701	1295781227	1295781227	WINNIE COMMUNITY HOSPITAL, LLC	Rural	Jefferson	Rural Jefferson	\$93,960	\$92,328	\$	40,620	141%	Yes
199602701	199602701	1316197767	1316197767	CRANE COUNTY HOSPITAL DISTRICT-CRANE MEMORIAL HOSPITAL	Rural	MISA West	Rural MISA West	\$85,611	\$59,065	\$	24,890	145%	Yes
136142011	136142011	1033118716	1033118716	CASTRO COUNTY HOSPITAL DISTRICT-PLAIN MEMORIAL HOSPITAL	Rural	MISA West	Rural MISA West	\$53,742	\$59,721	\$	47,083	199%	Yes
135233809	135233809	1992765511	1992765511	LAVACA MEDICAL CENTER	Rural	MISA Central	Rural MISA Central	\$85,102	\$79,877	\$	27,343	126%	Yes
094180903	094180903	1821068620	1821068620	LYNN COUNTY HOSPITAL DISTRICT	Rural	Lubbock	Rural Lubbock	\$130,193	\$62,982	\$	124,092	144%	Yes
152686501	152686501	1780786699	1780786699	PALACIOS COMMUNITY MEDICAL CENTER	Rural	Harris	Rural Harris	\$48,019	\$37,425	\$	50,225	183%	Yes
130089906	130089906	1225038938	1225038938	BALLINGER MEMORIAL HOSPITAL	Rural	MISA West	Rural MISA West	\$60,194	\$49,507	\$	35,008	140%	Yes
021189801	021189801	1023015120	1023015120	MILLWOOD HOSPITAL	Non-State-Owned	Tarrant	Non-State-Owned Tarrant	\$0	\$0	\$	-	N/A	Yes
319209801	319209801	1013941780	1013941780	GOVERNMENT LONG TERM CARE LP-COVANANT SPECIALTY HOSPITAL	Urban	Lubbock	Urban Lubbock	\$0	\$0	\$	-	N/A	Yes
199238002	199238002	1720279342	1720279342	HEALTHSOUTH REHABILITATION HOSPITAL OF RICHARDSON	Urban	Dallas	Urban Dallas	\$0	\$0	\$	-	N/A	Yes
121053605	121053605	1487639175	1487639175	KNOX COUNTY HOSPITAL DISTRICT-KNOX COUNTY HOSPITAL	Rural	MISA West	Rural MISA West	\$70,187	\$50,889	\$	28,216	113%	Yes
137343308	137343308	1861475626	1861475626	PARKER COUNTY COMMUNITY HOSPITAL	Rural	MISA West	Rural MISA West	\$77,119	\$51,763	\$	30,504	107%	Yes
020992601	020992601	1083612121	1083612121	STONEWALL MEMORIAL HOSPITAL DISTRICT-STONEWALL MEMORIAL HOSPITAL	Rural	MISA West	Rural MISA West	\$46,722	\$57,431	\$	21,563	169%	Yes
339865503	339865503	1184056954	1184056954	ROCK SPRINGS, LLC-	Non-State-Owned	Travis	Non-State-Owned Travis	\$0	\$0	\$	-	N/A	Yes
121193005	121193005	1538150370	1538150370	SHANKOFF GENERAL HOSPITAL	Rural	MISA West	Rural MISA West	\$0	\$6,716	\$	5,893	N/A	Yes
09588703	09588703	1058342421	1058342421	HEMPHILL COUNTY HOSPITAL	Rural	MISA West	Rural MISA West	\$75,253	\$49,715	\$	32,758	110%	Yes
126840107	126840107	1477594299	1477594299	PREFERRED LEASING INC-COLLINGSWORTH GENERAL HOSPITAL	Rural	MISA West	Rural MISA West	\$0	\$0	\$	-	N/A	Yes
112692202	112692202	1598746703	1598746703	FISHER COUNTY HOSPITAL-FISHER COUNTY HOSPITAL DISTRICT	Rural	MISA West	Rural MISA West	\$35,770	\$31,805	\$	32,230	179%	Yes
112728403	112728403	1083619712	1083619712	GENERAL HOSPITAL-IRAAN GENERAL HOSPITAL	Rural	MISA West	Rural MISA West	\$29,678	\$38,813	\$	14,559	179%	Yes
094172602	094172602	1023013935	1023013935	MCCAMEY HOSPITAL	Rural	MISA West	Rural MISA West	\$41,045	\$45,387	\$	25,860	174%	Yes
176584201	176584201	1013970862	1013970862	PREFERRED HOSPITAL LEASING VAN HORN INC-CUBERSON HOSPITAL	Rural	MISA West	Rural MISA West	\$967	\$249	\$	-	26%	Yes
179272301	179272301	1295764553	1295764553	PREFERRED HOSPITAL LEASING ELDORADO INC-SCHLEICHER COUNTY MEDICAL CENTER	Rural	MISA West	Rural MISA West	\$2,247	\$571	\$	2,912	155%	Yes
121787905	121787905	1396748471	1396748471	NORTH WHEELER COUNTY HOSPITAL DISTRICT-PARKVIEW HOSPITAL	Rural	MISA West	Rural MISA West	\$25,737	\$29,616	\$	16,737	180%	Yes
402628801	402628801	094204701	1730183658	WINKLER COUNTY HOSPITAL DISTRICT-WINKLER COUNTY MEMORIAL HOSPITAL	Rural	MISA West	Non-State-Owned Tarrant	\$55,835	\$34,134	\$	24,349	105%	Yes
359590201	359590201	1649646415	1649646415	GARLAND BEHAVIORAL HOSPITAL	Non-State-Owned	Dallas	Non-State-Owned Dallas	\$0	\$0	\$	-	N/A	Yes
120745806	120745806	1699770149	1699770149	MUENSTER HOSPITAL DISTRICT-MUENSTER MEMORIAL HOSPITAL	Rural	MISA Northeast	Rural MISA Northeast	\$23,216	\$36,500	\$	17,984	235%	Yes
094382101	094382101	1538264866	1538264866	SETON SHOAL CREEK HOSPITAL	Non-State-Owned	Travis	Non-State-Owned Travis	\$0	\$0	\$	-	N/A	Yes
121799406	121799406	1295739258	1295739258	RANKIN COUNTY HOSPITAL DISTRICT	Rural	MISA West	Rural MISA West	\$15,649	\$34,140	\$	19,334	342%	Yes
102996002	102996002	1962614834	1962614834	HORIZON HEALTH AUSTIN INC-AUSTIN LAKES HOSPITAL	Non-State-Owned	Travis	Non-State-Owned Travis	\$0	\$0	\$	-	N/A	Yes
021175701	021175701	1649243353	1649243353	HEALTHSOUTH REHABILITATION OF TEXARKANA INC-ENCOMPASS HEALTH REHABILITATION HOSPITAL OF TEXARK	Urban	MISA Northeast	Urban MISA Northeast	\$0	\$0	\$	65	N/A	Yes
088189803	088189803	1356418974	1356418974	THROCKMORTON COUNTY MEMORIAL HOSPITAL-	Rural	MISA West	Rural MISA West	\$5,744	\$15,181	\$	11,066	300%	Yes
133257904	133257904	1841354677	1841354677	Texas DSHS TCID	State-Owned Non-IMD	Bexar	State-Owned Non-IMD Bexar	\$0	\$0	\$	-	N/A	Yes
388635001	388635001	1013085083	1013085083	SCOTT & WHITE CONTINUING CARE HOSPITAL-BAYLOR SCOTT & WHITE CONTINUING CARE HOSPITAL	Urban	MISA Central	Urban MISA Central	\$0	\$0	\$	922	N/A	Yes
021219301	021219301	1821161167	1821161167	Texas HISC Rio Grande State Center	State-Owned IMD	Hidalgo	State-Owned IMD Hidalgo	\$0	\$0	\$	-	N/A	Yes
314300001	314300001	1134401466	1134401466	CARROLLTON SPRINGS LLC	Non-State-Owned	Tarrant	Non-State-Owned Tarrant	\$0	\$0	\$	-	N/A	Yes
342897103	342897103	1306268321	1306268321	WORTH COUNTY HOSPITAL-SCOTT & CATHERINE HOSPITAL-HOUSTON METHODIST CONTINUING CARE HOSPITAL	Urban	Harris	Urban Harris	\$0	\$0	\$	-	N/A	Yes
094205403	094205403	1730278417	1730278417	TEXAS HEALTH SPECIALTY HOSPITAL FORT WORTH-	Urban	Tarrant	Urban Tarrant	\$0	\$0	\$	-	N/A	Yes
330388501	330388501	1194753590	1194753590	TRIUMPH MANAGEMENT COMPANY LLC-BAYLOR SCOTT AND WHITE THE HEART HOSPITAL DENTON	Urban	Tarrant	Urban Tarrant	\$130,863	\$22,519	\$	-	17%	Yes
184505902	184505902	1316911068	1316911068	TRINITY MOTHER FRANCES REHABILITATION HOSPITAL-CHRISTUS TRINITY MOTHER FRANCES REHABILITATION HOS	Urban	MISA Northeast	Urban MISA Northeast	\$0	\$0	\$	-	N/A	Yes
094352403	094352403	1194798801	1194798801	HEALTHSOUTH REHABILITATION HOSPITAL THE WOODLANDS-ENCOMPASS HEALTH REHABILITATION HOSPITAL OF THE W	Urban	Harris	Urban Harris	\$0	\$0	\$	-	N/A	Yes
315341301	315341301	1376829812	1376829812	HEALTHSOUTH REHABILITATION HOSPITAL OF THE W	Urban	Harris	Urban Harris	\$0	\$0	\$	-	N/A	Yes
094349003	094349003	1689648339	1689648339	REHABILITATION HOSPITAL OF THE VILLAGE	Urban	MISA West	Urban MISA West	\$0	\$0	\$	-	N/A	Yes
219907701	219907701	1518287721	1518287721	CPS REHAB OF WF LP-ENCOMPASS HEALTH REHABILITATION HOSPITAL OF WICHIT	Urban	Harris	Urban Harris	\$0	\$0	\$	-	N/A	Yes
209804801	209804801	1477731156	1477731156	HEALTHSOUTH REHABILITATION HOSPITAL OF SUGAR LAND-HEALTHSOUTH SUGAR LAND REHABILITATION HOSPITAL	Urban	Harris	Urban Harris	\$0	\$0	\$	-	N/A	Yes
337018101	337018101	1366871600	1366871600	HEALTHSOUTH REHABILITATION HOSPITAL NORTH HOUSTON-ENCOMPASS HEALTH SOUTH REHABILITATION HOSPITAL VISION PA	Urban	Harris	Urban Harris	\$0	\$0	\$	-	N/A	Yes
301006801	301006801	1275813610	1275813610	HEALTH SOUTH REHABILITATION HOSPITAL OF HUMBLE-	Urban	Harris	Urban Harris	\$0	\$0	\$	-	N/A	Yes
288662403	288662403	1427374222	1427374222	HEALTHSOUTH REHAB HOSPITAL OF THE MID-CITIES LLC-RELIANT REHABILITATION HOSPITAL MID CITIES	Urban	Harris	Urban Harris	\$0	\$0	\$	-	N/A	Yes
199329202	199329202	1699749341	1699749341	REHABILITATION HOSPITAL OF CITY OF AUSTIN REHABILITATION HOSPITAL-ENCOMPASS HEALTH REHABILITATION HOSPITAL OF ARLINGTON	Urban	Tarrant	Urban Tarrant	\$0	\$0	\$	-	N/A	Yes
021173202	021173202	1821062050	1821062050	HEALTHSOUTH REHABILITATION HOSPITAL OF ARLINGTON	Urban	Tarrant	Urban Tarrant	\$0	\$0	\$	-	N/A	Yes
127962703	127962703	1073511762	1073511762	BAYLOR MEDICAL CENTER GRAPEVINE-BAYLOR SCOTT AND WHITE MEDICAL CENTER- GRAPEVINE	Urban	Tarrant	Urban Tarrant	\$975,015	\$119,292	\$	-	12%	Yes
133331202	133331202	1942218581	1942218581	Texas HISC Rusk State Hospital	State-Owned IMD	MISA Northeast	State-Owned IMD MISA Northeast	\$0	\$0	\$	-	N/A	Yes
137918204	137918204	1881600682	1881600682	Texas HISC Big Spring State Hospital	State-Owned IMD	MISA West	State-Owned IMD MISA West	\$0	\$0	\$	-	N/A	Yes
127320302	127320302	1407862170	1407862170	Texas HISC Kerrville State Hospital	State-Owned IMD	MISA West	State-Owned IMD MISA West	\$0	\$0	\$	-	N/A	Yes
339487601	339487601	1366880627	1366880627	MESA SPRINGS, LLC-	IMD	Tarrant	Non-State-Owned Tarrant	\$0	\$0	\$	-	N/A	Yes
418113301	418113301	3522737301	1821612284	Kindred BH Acquisition 1, LLC d/b/a WellBridge Hospital Greater Dallas	Non-State-Owned	Dallas	Non-State-Owned Dallas	\$0	\$0	\$	-	N/A	Yes
415930301	415930301	1285258640	1285258640	Kindred BH Acquisition 2, LLC d/b/a WellBridge Healthcare Fort Worth	IMD	Tarrant	Non-State-Owned Tarrant	\$0	\$0	\$	-	N/A	Yes
414962701	414962701	1942795133	1942795133	Ascension Seton Bastrop	Non-State-Owned	Tarrant	Non-State-Owned Tarrant	\$0	\$0	\$	-	N/A	Yes
400811201	400811201	1346724879	1346724879	El Paso Behavioral Health, LLC DBA Rio Vista Behavioral Health	Urban	Travis	Urban Travis	\$0	\$0	\$	612	N/A	Yes
					IMD	El Paso	Non-state-owned IMD El Paso	\$0	\$0	\$	-	N/A	Yes



414763901	414763901	1104381292	1104381292	Texas Health Frisco	Urban	Dallas	Urban Dallas	\$0	\$0	\$	-	N/A	Yes
382091201	382091201	1144756578	1144756578	Encompass Health Rehabilitation Hospital of Pearland	Urban	Harris	Urban Harris	\$0	\$0	\$	-	N/A	Yes
413256501	413256501	1154893675	1154893675	South Plains Rehabilitation Hospital, an affiliate of UMC and Encompass Health	Urban	Lubbock	Urban Lubbock	\$0	\$0	\$	-	N/A	Yes
Pending 1	#N/A	1356960132	1356960132	Texas Health Hospital Mansfield	Urban	Tarrant	Urban Tarrant	\$0	\$0	\$	-	N/A	Yes
Pending 2	#N/A	1487271375	1487271375	Methodist Midwestern Medical Center	Urban	Dallas	Urban Dallas	\$0	\$0	\$	-	N/A	Yes
407926101	407926101	1144781501	1144781501	BAYLOR SCOTT & WHITE MEDICAL CENTERS - CAPITOL AREA	Urban	Travis	Urban Travis	\$0	\$0	\$	74,506	N/A	Yes
138644310	138644310	1528064649	1528064649	Hendrick Medical Center ABILENE	Urban	MRSA West	Urban MRSA West	\$9,563,321	\$3,212,913	\$	7,013,735	107%	Yes
380473401	380473401	1003344334	1003344334	HON EP HORIZON CITY LLC- THE HOSPITALS OF PROVIDENCE HORIZON CITY CAMPUS	Urban	El Paso	Urban El Paso	\$4,786,705	\$2,559,698	\$	2,375,543	103%	Yes

CHIRP - Inpatient Payment Analysis for Hospitals Only Participating in UHRIP (Comparison to ACR)

Totals: 176 Hospitals													
2021 Master TPI	TPI	Master NPI	NPI	PROVIDER NAME	CHIRP Class	SDA	Combined Rates Class & SDA	IP ACR UPL	Total IP Medicaid Base Payments (without NMP)	NMP in UPL Text	P UHRIP Payment	Total Inpatient Payment compared to ACR	Inpatient: UHRIP Only
127805107	127805107	1982666111	1982666111	MEMORIAL HERMANN HOSPITAL SYSTEM-HHHS HERMANN HOSPITAL	Urban	Harris	Urban Harris	\$301,835,923	\$103,541,265	\$0	\$230,116,181	111%	Yes
136141205	136141205	1821011248	1821011248	BEAR COUNTRY HOSPITAL DISTRICT-UNIVERSITY HEALTH SYSTEM	Urban	Bear	Urban Bear	\$83,967,581	\$46,171,339	\$54,898,134	\$26,031,011	151%	Yes
020834001	020834001	1270132214	1270132214	MEMORIAL HERMANN HEALTH SYSTEM-HHHS THE WOODLANDS HOSPITAL	Urban	Harris	Urban Harris	\$144,664,181	\$47,037,344	\$0	\$101,538,971	103%	Yes
133355104	133355104	1205900370	1205900370	FAIRBANKS HOSPITAL DISTRICT	Urban	Harris	Urban Harris	\$21,126,678	\$21,126,678	\$45,094,243	\$45,094,243	N/A	Yes
137999206	137999206	1821087164	1821087164	UNIVERSITY MEDICAL CENTER	Urban	Lubbock	Urban Lubbock	\$50,844,397	\$21,237,419	\$54,735,057	\$54,735,057	149%	Yes
127300503	127300503	1184622847	1184622847	CHI ST LUKE'S HEALTH BAYLOR COLLEGE OF MEDICINE MED	Urban	Harris	Urban Harris	\$52,006,114	\$16,059,542	\$0	\$35,824,227	100%	Yes
020817501	020817501	1174576698	1174576698	CHCA BAYSHORE LP-HCA HOUSTON HEALTHCARE SOUTHEAST	Urban	Harris	Urban Harris	\$35,402,494	\$104,38,181	\$0	\$25,647,443	148%	Yes
181706601	181706601	1154361475	1154361475	SAINT JOSEPH MEDICAL CENTER	Urban	Harris	Urban Harris	\$32,677,072	\$14,718,876	\$0	\$37,715,587	107%	Yes
020841501	020841501	1740450121	1740450121	MEDICAL CENTER	Urban	Harris	Urban Harris	\$33,918,559	\$10,889,524	\$0	\$27,558,435	113%	Yes
020841501	020841501	1962455816	1962455816	CHCA CONROE LP-HCA HOUSTON HEALTHCARE CONROE	Urban	Harris	Urban Harris	\$19,577,359	\$6,599,039	\$0	\$17,597,832	128%	Yes
138951211	138951211	1316936990	1316936990	PASO COUNTY HOSPITAL DISTRICT-UNIVERSITY MEDICAL CENTER OF EL PASO	Urban	El Paso	Urban El Paso	\$10,160,335	\$5,688,506	\$26,959,911	\$7,643,643	330%	Yes
391575301	391575301	1083112023	1083112023	PIPELINE EAST DALLAS LLC-CITY HOSPITAL AT WHITE ROCK	Urban	Dallas	Urban Dallas	\$11,133,099	\$7,555,112	\$0	\$6,900,762	330%	Yes
354178101	354178101	1720480627	1720480627	CHILDREN'S MEDICAL CENTER OF DALLAS-CHILDREN'S MEDICAL CENTER	Children's	Dallas	Children's Dallas	\$13,982,414	\$8,057,031	\$0	\$6,900,762	118%	Yes
136143806	136143806	1255325817	1255325817	MIDLAND COUNTY HOSPITAL DISTRICT-MIDLAND MEMORIAL HOSPITAL	Urban	MSA West	Urban MSA West	\$10,897,424	\$4,485,369	\$9,534,909	\$241,002	151%	Yes
127030903	127030903	1700883196	1700883196	OAK BEND MEDICAL CENTER-OMBER MEDICAL CENTER	Urban	Harris	Urban Harris	\$4,968,742	\$2,780,055	\$0	\$5,387,906	164%	Yes
377705401	377705401	1750819025	1750819025	NORTH HOUSTON TMMC LLC-TOMBALL REGIONAL MEDICAL CENTER	Urban	Harris	Urban Harris	\$9,664,436	\$3,019,788	\$0	\$7,360,501	107%	Yes
166630301	166630301	1942208616	1942208616	ST LUKE'S COMMUNITY HEALTH SERVICES-ST LUKE'S THE WOODLANDS HOSPITAL	Urban	Harris	Urban Harris	\$9,442,417	\$3,192,124	\$0	\$8,092,890	120%	Yes
080600101	080600101	1972517365	1972517365	ST LUKE'S COMMUNITY COVENANT MEDICAL CENTER	Urban	Lubbock	Urban Lubbock	\$3,128,184	\$0	\$0	\$3,128,184	N/A	Yes
286019501	286019501	1659559573	1659559573	ST LUKE'S COMMUNITY DEVELOPMENT CORPORATION-SUGAR ST. LUKES SUGAR LAND HOSPITAL	Urban	Harris	Urban Harris	\$6,375,638	\$2,295,439	\$0	\$5,300,601	119%	Yes
339153401	339153401	1710314141	1710314141	SAINT LUKE'S AT VINTAGE	Urban	Harris	Urban Harris	\$4,982,322	\$1,668,810	\$0	\$5,624,233	148%	Yes
112671602	112671602	1972581940	1972581940	COMMUNITY HOSPITAL OF BRAZOSPORT-BRAZOSPORT REGIONAL HEALTH SYSTEM	Urban	Harris	Urban Harris	\$1,274,920	\$757,321	\$0	\$1,384,026	168%	Yes
127278304	127278304	1417941295	1417941295	UNIVERSITY OF TEXAS HEALTH AND SCIENCE CENTER AT TYLER	Non-State-owned	MSA Northeast	Non-State-owned MSA Northeast	\$234,977	\$369,739	\$0	\$0	115%	Yes
415586001	415586001	121798903	121798903	CHRISTUS Santa Rosa Hospital-San Marcos	Urban	Travis	Urban Travis	\$1,260,253	\$0	\$0	\$1,260,253	N/A	Yes
412747401	412747401	1442525699	1442525699	WALKER COUNTY HOSPITAL CORPORATION-HUNTSVILLE MEMORIAL HOSPITAL	Urban	Jefferson	Urban Jefferson	\$1,056,057	\$0	\$86	\$0	N/A	Yes
131030203	131030203	1801831748	1801831748	NACOGDOCHES COUNTY HOSPITAL DISTRICT MEMORIAL HOSPITAL	Rural	MSA Northeast	Rural MSA Northeast	\$3,361,746	\$3,914,127	\$0	\$0	116%	Yes
409323001	409323001	1053963009	1053963009	COLLEGE STATION MEDICAL CENTER	Urban	MSA Central	Urban MSA Central	\$603,588	\$0	\$134,313	\$0	N/A	Yes
34059101	34059101	1871917971	1871917971	SAN ANTONIO BEHAVIORAL HEALTHCARE HOSPITAL, LLC-	Non-State-owned	Bear	Non-State-owned IMD	\$0	\$3,387,502	\$0	\$404,146	N/A	Yes
121829905	121829905	1598764359	1598764359	WEST OAK HOSPITAL INC-TEXAS WEST OAKS HOSPITAL	IMD	Harris	State-owned IMD	\$4,553,229	\$3,443,017	\$0	\$1,059,018	103%	Yes
112742803	112742803	1326015595	1326015595	Clarify Child Guidance Center	Non-State-owned	Bear	Non-State-owned IMD	\$2,996,998	\$45,70,341	\$0	\$414,595	180%	Yes
333892001	333892001	1457791105	1457791105	DALLAS BEHAVIORAL HEALTHCARE HOSPITAL, LLC-	IMD	Dallas	State-owned IMD MSA	\$4,019,354	\$2,998,546	\$0	\$1,323,250	108%	Yes
021196301	021196301	1245344472	1245344472	TXDSH dx North Texas State Hospital-Vernon	State-owned	MSA West	State-owned IMD	\$742,982	\$1,170,990	\$0	\$798,147	265%	Yes
130953004	130953004	1679678767	1679678767	WYKORCA COUNTY HOSPITAL DISTRICT-MATAGORDA REGIONAL MEDICAL CENTER	Rural	Harris	Rural Harris	\$1,341,257	\$2,103,634	\$0	\$209,584	180%	Yes
387381201	387381201	1730697350	1730697350	JACKSONVILLE HOSPITAL LLC-UT HEALTH EAST TEXAS JACKSONVILLE HOSPITAL	Rural	MSA Northeast	Rural MSA Northeast	\$2,085,319	\$2,504,205	\$0	\$0	120%	Yes
112697102	112697102	1689650616	1689650616	MEMORIAL HOSP OF POLK COUNTY-CHI ST LUKES HEALTH REHABILITATION	Rural	Jefferson	Rural Jefferson	\$2,791,032	\$3,183,520	\$0	\$0	121%	Yes
112746602	112746602	1922078815	1922078815	CHRISTUS SPROHLY HEALTH SYSTEM CORPORATION-CHRISTUS SPROHLY	IMD	Dallas	Non-State-owned IMD	\$123,013	\$91,509	\$0	\$30,870	99%	Yes
020811801	020811801	1447228747	1447228747	GLEN OAKS HOSPITAL INC-GLEN OAKS HOSPITAL	Rural	Nueces	Rural Nueces	\$1,984,679	\$1,676,027	\$0	\$446,431	107%	Yes
281219001	281219001	1407990088	1407990088	HOSPITAL BEEVILLE	Urban	Harris	Urban Harris	\$1,437,598	\$485,803	\$0	\$1,234,817	120%	Yes
387777001	387777001	1326546797	1326546797	HENDERSON PATIENTS MEDICAL CENTER-	Rural	MSA Northeast	Rural MSA Northeast	\$1,450,540	\$1,670,566	\$0	\$0	129%	Yes
031203701	031203701	1720187568	1720187568	CORPUS CREEK HOSPITAL, INC	Non-State-owned	Harris	Non-State-owned IMD	\$3,037,187	\$2,163,607	\$0	\$844,778	103%	Yes
388217701	388217701	1801826839	1801826839	BAYLOR SCOTT & WHITE MEDICAL CENTER - CENTENNIAL	Urban	Dallas	Urban Dallas	\$770,199	\$405,193	\$0	\$145,964	146%	Yes
136332703	136332703	1769567085	1769567085	STARBUCKS MEMORIAL HOSPITAL	Urban	Hidalgo	Urban Hidalgo	\$528,590	\$0	\$0	\$528,590	N/A	Yes
094351601	094351601	1821061532	1821061532	HEALTHSOUTH REHABILITATION-ENCOMPASS HEALTH REHABILITATION	Urban	MSA West	Urban MSA West	\$913,140	\$608,426	\$0	\$350,107	105%	Yes
348990801	348990801	1680989790	1680989790	HOUSTON BEHAVIORAL HEALTHCARE HOSPITAL, LLC	IMD	Harris	Non-State-owned IMD	\$1,951,591	\$1,422,163	\$0	\$682,836	108%	Yes
021168201	021168201	1548233265	1548233265	HEALTHSOUTH REHABILITATION-ENCOMPASS HEALTH REHABILITATION	Urban	Bear	Urban Bear	\$535,072	\$272,449	\$0	\$272,449	130%	Yes
138950412	138950412	1972590602	1972590602	PALO PINTO GENERAL HOSPITAL	Rural	MSA West	Urban MSA West	\$966,558	\$1,237,238	\$4,304,984	\$8,184	57%	Yes
021215104	021215104	1689692402	1689692402	HHH CEDAR CREST LLC-CEDAR CREST HOSPITAL	Non-State-owned	MSA Central	MSA Central	\$2,313,873	\$1,926,192	\$0	\$1,208,851	135%	Yes
313188001	313188001	1659539567	1659539567	HEALTHSOUTH REHABILITATION HOSPITAL OF ABILENE LLC-HEALTHSOUTH	Urban	MSA West	Urban MSA West	\$640,914	\$459,450	\$0	\$286,655	117%	Yes
135226205	135226205	1154315307	1154315307	SCOTT & WHITE HOSPITAL BRENHAW-BAYLOR SCOTT AND WHITE MEDICAL CENTER BRENHAW	Rural	MSA Central	Rural MSA Central	\$1,680,372	\$1,588,027	\$0	\$209,772	174%	Yes
197063401	197063401	1841497153	1841497153	GPCH LLC-GOLDEN PLAINS COMMUNITY HOSPITAL	Rural	Lubbock	Rural Lubbock	\$1,161,866	\$895,924	\$0	\$1,131,244	107%	Yes
127298107	127298107	1174563779	1174563779	ANDREWS COUNTY HOSPITAL DISTRICT	Rural	MSA West	Rural MSA West	\$507,823	\$1,041,976	\$0	\$43,158	214%	Yes
133258705	133258705	1225146400	1225146400	METHODIST HOSPITAL LEVELLAND-COVANANT HOSPITAL LEVELLAND	Rural	Lubbock	Rural Lubbock	\$2,092,017	\$1,051,309	\$0	\$1,089,109	102%	Yes
132444705	132444705	1275581852	1275581852	ROLLING PLAINS MEMORIAL HOSPITAL	Rural	MSA West	Rural MSA West	\$609,983	\$1,052,492	\$0	\$49,373	181%	Yes
405102101	405102101	1285191452	1831160423	SCENIC MOUNTAIN MEDICAL CENTER	Rural	MSA West	Rural MSA West	\$0	\$1,454,947	\$0	\$31,092	N/A	Yes
344854001	344854001	1215354899	1215354899	WESTPARK SPRINGS LLC-	IMD	Harris	Non-State-owned IMD	\$0	\$906,382	\$0	\$292,276	N/A	Yes
133544006	133544006	1568454403	1568454403	DEAN SMITH COUNTY HOSPITAL DISTRICT-THEFORD REGIONAL MEDICAL CENTER	Rural	Lubbock	Rural Lubbock	\$772,703	\$489,947	\$0	\$511,811	130%	Yes
021195501	021195501	1477669208	1477669208	Texas HHS North Texas State Hospital-Wichita	State-owned	MSA West	State-owned IMD MSA West	\$531,684	\$407,279	\$0	\$218,993	118%	Yes
112745802	112745802	1518937218	1518937218	RIVER CREST HOSPITAL	Non-State-owned	MSA West	Non-State-owned IMD	\$1,220,505	\$1,062,504	\$0	\$346,251	107%	Yes
094121303	094121303	1821025990	1821025990	MEMORIAL HOSPITAL	Rural	MSA West	Rural MSA West	\$0	\$781,975	\$0	\$0	N/A	Yes
137909111	137909111	1689630865	1689630865	MEMORIAL MEDICAL CENTER	Rural	Nueces	Rural Nueces	\$790,403	\$707,087	\$0	\$159,686	110%	Yes

220238402	220238401	1043457583	1043457583	MEMORIAL HERMAN REHABILITATION HOSPITAL KATY- WILSON COUNTY MEMORIAL HOSPITAL DISTRICT-CONALLY MEMORIAL MEDICAL CENTER	Urban	Harris	Urban Harris	\$0	\$0	-		N/A	Yes
135151206	135151206	187159829	187159829	INCH OF HILLSBORO INC-HILL REGIONAL HOSPITAL	Rural	Bexar	Rural Bexar	\$159,668	\$134,562	\$0	\$8,449	140%	Yes
133252009	133252009	199228582	199228582	Texas Department of State Health Services dba Austin State Hospital	Rural	MSA Central	Rural MSA Central	\$0	\$905,705	\$0	\$11,133	174%	Yes
1021194801	1021194801	1326052226	1326052226	PECCOS COUNTY HOSPITAL DISTRICT-CHILDREN REGIONAL MEDICAL CENTER	State-Owned IMD	Travis	State-Owned IMD Travis	\$486,994	\$515,962	\$0	\$29,995	174%	Yes
133250406	133250406	1326079534	1326079534	PITTSBURG HOSPITAL LLC-UT HEALTH EAST TEXAS PITTSBURG HOSPITAL	Rural	MSA West	Rural MSA West	\$854,079	\$495,501	\$3,502,940	\$31,031	472%	Yes
388696201	388696201	1184132524	1184132524	COLUMBUS COMMUNITY HOSPITAL- JACOBSONVILLE	Rural	MSA Northeast	Rural MSA Northeast	\$257,074	\$343,875	\$0	\$116,516	134%	Yes
135033210	135033210	1740238641	1740238641	MOTHER FRANCES HOSPITAL- JACOBSONVILLE	Rural	MSA Central	Rural MSA Central	\$558,530	\$719,018	\$0	\$171,434	159%	Yes
141858401	141858401	1952306672	1952306672	GEORGETOWN BEHAVIORAL HEALTH INSTITUTE, LLC-GEORGETOWN	IMD	MSA Northeast	Rural MSA Northeast	\$18,928	\$19,434	\$0	-	103%	Yes
345305201	345305201	1279596807	1279596807	BEHAVIORAL HEALTH INSTITUTE LLC	Non-State-Owned	Travis	Non-State-Owned IMD	\$0	\$1,193,459	\$0	\$29,024	N/A	Yes
137919003	137919003	1992713119	1992713119	Texas Department of State Health Services dba Terrell State Hospital	State-Owned IMD	Dallas	State-Owned IMD Dallas	\$676,318	\$264,449	\$0	\$749,221	150%	Yes
348183001	348183001	1144625153	1144625153	AUSTIN BEHAVIORAL HOSPITAL LLC-CROSS CREEK HOSPITAL	Non-State-Owned	Travis	Non-State-Owned IMD	\$1,420,929	\$1,170,354	\$0	\$51,702	119%	Yes
140714001	140714001	1861487779	1861487779	LIMESTONE MEDICAL CENTER	Rural	MSA Central	Rural MSA Central	\$10,661	\$10,661	\$0	\$10,661	158%	Yes
311054601	311054601	1003192311	1003192311	CONRO RIVER REGIONAL HOSPITAL	Rural	Harris	Rural Harris	\$116,033	\$98,603	\$0	\$18,340	101%	Yes
094347402	094347402	1144294893	1144294893	HEALTHSOUTH REHABILITATION HOSPITAL LLC-HEALTHSOUTH PLANO REHABILITATION HOSPITAL	Urban	Dallas	Urban Dallas	\$303,585	\$215,050	\$0	\$177,682	129%	Yes
333366801	333366801	1750620456	1750620456	OCEANS BEHAVIORAL HOSPITAL OF ARLINE LLC- BEHAVIORAL HOSPITAL OF PERMAN BASIN LLC-OCEANS BEHAVIORAL HOSPITAL OF PERMAN BASIN	IMD	MSA West	Non-State-Owned IMD	\$0	\$756,647	\$0	\$269,461	N/A	Yes
130658501	130658501	1396184180	1396184180	REEVES COUNTY HOSPITAL DISTRICT	Non-State-Owned	MSA West	Non-State-Owned IMD	\$914,902	\$302,451	\$0	\$217,463	101%	Yes
172684904	172684904	1831170273	1831170273	REEVES COUNTY HOSPITAL DISTRICT	Rural	MSA West	Rural MSA West	\$775,307	\$669,815	\$0	\$26,384	166%	Yes
314562901	314562901	1982920773	1982920773	WOODLAND SPRINGS LLC-WOODLAND SPRINGS	IMD	Harris	Non-State-Owned IMD	\$0	\$723,218	\$0	\$281,129	N/A	Yes
391576104	391576104	1114435260	1114435260	PRIO HOSPITAL-PRIO REGIONAL SWING BED	Rural	MSA West	Rural MSA West	\$199,284	\$232,328	\$0	\$19,450	126%	Yes
112688004	112688004	1447574819	1447574819	HEALTHSOUTH REHABILITATION HOSPITAL OF DALLAS LLC-HEALTHSOUTH REHABILITATION HOSPITAL OF DALLAS	Urban	Dallas	Urban Dallas	\$269,909	\$192,950	\$0	\$194,215	143%	Yes
134562901	134562901	1982920773	1982920773	CROCKETT MEDICAL CENTER LLC-CROCKETT MEDICAL CENTER	Urban	MSA Northeast	Rural MSA Northeast	\$0	\$35,878	\$0	-	N/A	Yes
309190201	309190201	1760598692	1760598692	PECCOS COUNTY MEMORIAL HOSPITAL-	Rural	MSA West	Rural MSA West	\$443,317	\$428,662	\$0	\$25,281	102%	Yes
269190201	269190201	1245422567	1245422567	HEALTHSOUTH REHABILITATION HOSPITAL OF ROUND ROCK	Urban	Travis	Urban Travis	\$250,410	\$178,500	\$0	\$128,813	123%	Yes
210433301	210433301	1427048743	1427048743	RED RIVER HOSPITAL LLC-RED RIVER HOSPITAL	IMD	MSA West	Non-State-Owned IMD	\$77,186	\$604,533	\$0	\$209,514	132%	Yes
121027401	121027401	1184868879	1184868879	ST LUKES LAKESIDE HOSPITAL LLC-ST LUKES LAKESIDE HOSPITAL	Urban	Harris	Urban Harris	\$671,365	\$24,305	\$0	\$160,320	239%	Yes
020988401	020988401	1023011657	1023011657	SWERNY COMMUNITY HOSPITAL	Rural	Harris	Rural Harris	\$61,102	\$76,704	\$0	\$10,445	143%	Yes
176692901	176692901	1659362630	1659362630	ST MARKS MEDICAL CENTER	Rural	Travis	Rural Travis	\$259,010	\$303,653	\$0	\$54,476	138%	Yes
020990001	020990001	1780731737	1780731737	MADISON ST JOSEPH HEALTH CENTER	Rural	MSA Central	Rural MSA Central	\$0	\$968	\$0	\$968	N/A	Yes
136333101	136333101	1720096019	1720096019	COUNTY OF WARD-WARD MEDICAL HOSPITAL	Rural	MSA West	Rural MSA West	\$45,182	\$79,417	\$0	\$7,055	191%	Yes
386423401	386423401	1932573417	1932573417	ST JOSEPH HEALTHSOUTH REHABILITATION HOSPITAL LLC-CHI ST JOSEPH REHABILITATION HOSPITAL	Urban	MSA Central	Urban MSA Central	\$221,582	\$137,700	\$0	\$128,143	120%	Yes
121808305	121808305	1124061882	1124061882	JACKSON COUNTY HOSPITAL DISTRICT-JACKSON HEALTHCARE CENTER	Rural	MSA Central	Rural MSA Central	\$13,095	\$32,293	\$0	\$5,782	291%	Yes
389645801	389645801	174021695	174021695	REHABILITATION HOSPITAL LLC-OF HEALTH EAST TEXAS REHABILITATION HOSPITAL	Urban	MSA Northeast	Urban MSA Northeast	\$0	\$11,599	\$0	\$22,072	N/A	Yes
346945401	346945401	1881691061	1881691061	GRAHAM HOSPITAL DISTRICT -	Rural	MSA West	Rural MSA West	\$79,657	\$98,275	\$0	\$7,170	128%	Yes
147918003	147918003	1154317774	1154317774	GRIMES ST JOSEPH HEALTH CENTER	Rural	MSA Central	Rural MSA Central	\$0	\$595	\$0	\$595	N/A	Yes
130826407	130826407	1639176456	1639176456	COON MEMORIAL HOSPITAL	Rural	MSA West	Rural MSA West	\$155,314	\$197,691	\$0	\$7,934	132%	Yes
022991801	022991801	1942240189	1942240189	REFUGIO COUNTY MEMORIAL HOSPITAL DISTRICT	Rural	Nueces	Rural Nueces	\$13,629	\$24,300	\$0	\$11,980	266%	Yes
127301306	127301306	1659308948	1659308948	MOTHER FRANCES HOSPITAL WINNSBORO	Rural	MSA Northeast	Rural MSA Northeast	\$5,047	\$15,120	\$0	-	188%	Yes
136492909	136492909	1265648513	1265648513	LUBBOCK REGIONAL MHSR CENTER	State-Owned	Lubbock	State-Owned IMD Lubbock	\$913	\$4,198	\$0	-	466%	Yes
281406304	281406304	1346544616	1346544616	COMANCHE COUNTY MEDICAL CENTER-COMANCHE COUNTY MEDICAL CENTER	Rural	MSA Central	Rural MSA Central	\$99,508	\$113,551	\$0	\$13,303	127%	Yes
112725003	112725003	1793772789	1793772789	BURLESON ST JOSEPH HEALTH CENTER-BURLESON ST JOSEPH HEALTH CENTER	Rural	MSA Central	Rural MSA Central	\$20,316	\$20,674	\$0	\$4,164	122%	Yes
112704504	112704504	1245237593	1245237593	ENTHUSIASTIC GENERAL HOSPITAL	Rural	MSA West	Rural MSA West	\$16,417	\$24,711	\$0	\$12,561	105%	Yes
17461001	17461001	1629064928	1629064928	SOUTHAKE SPECIALTY HOSPITAL LLC-TEXAS HEALTH HARRIS MEMORIST HOSPITAL SOUTHLAKE	Urban	Tarrant	Urban Tarrant	\$67,919	\$0	\$0	-	0%	Yes
316360201	316360201	1407121189	1407121189	PREFERRED HOSPITAL LEASING COLEMAN INC-COLEMAN COUNTY MEDICAL CENTER COMPANY	Rural	MSA West	Rural MSA West	\$180,429	\$192,009	\$0	\$5,832	110%	Yes
138706004	138706004	1972511921	1972511921	Texas Department of State Health Services dba San Antonio State Hospital	State-Owned IMD	Bexar	State-Owned IMD Bexar	\$66,404	\$98,050	\$0	\$40,867	209%	Yes
284333604	284333604	1154324952	1154324952	STANTON COUNTY HOSPITAL DISTRICT NO 1-LIBERTY DAYTON REGIONAL MEDICAL CENTER	Rural	Jefferson	Rural Jefferson	\$40,364	\$50,915	\$0	-	126%	Yes
127313803	127313803	1708854288	1708854288	LAMB HEALTHCARE CENTER	Rural	Lubbock	Rural Lubbock	\$135,529	\$156,789	\$0	\$191,945	257%	Yes
220798701	220798701	1326349986	1326349986	SCOTT AND WHITE HOSPITAL - LLANO-BAYLOR SCOTT AND WHITE MEDICAL CENTER - LLANO	Rural	MSA Central	Rural MSA Central	\$0	\$15,347	\$0	\$6	N/A	Yes
020993401	020993401	1174522494	1174522494	BAYSIDE COMMUNITY HOSPITAL-	Rural	Jefferson	Rural Jefferson	\$18,349	\$39,266	\$0	-	215%	Yes
37991901	37991901	1285065623	1285065623	STEPHENS MEMORIAL HOSPITAL	Rural	MSA West	Rural MSA West	\$40,089	\$31,753	\$0	-	79%	Yes
136145310	136145310	1679560866	1679560866	MARTIN COUNTY HOSPITAL DISTRICT	Rural	MSA West	Rural MSA West	\$6,353	\$34,276	\$0	\$3,030	387%	Yes
121692107	121692107	1861510521	1861510521	HARDEN COUNTY MEMORIAL HOSPITAL	Rural	MSA West	Rural MSA West	\$17,228	\$26,088	\$0	\$1,577	161%	Yes
200683301	200683301	1932379856	1932379856	PREFERRED HOSPITAL LEASING HEMPHILL INC-SABINE COUNTY HOSPITAL	Rural	MSA Northeast	Rural MSA Northeast	\$26,197	\$26,197	\$0	-	150%	Yes
130734007	130734007	1578547345	1578547345	MEMORIAL MEDICAL CENTER LLC-TEXAS HEALTH CENTER FOR PHYSICIANS MEDICAL CENTER LLC-TEXAS HEALTH CENTER FOR PHYSICIANS MEDICAL CENTER	Rural	MSA Northeast	Rural MSA Northeast	\$35,337	\$53,974	\$0	-	153%	Yes
174626001	174626001	1316933609	1316933609	DIAGNOSTICS AND SURGERY PL	Urban	Dallas	Urban Dallas	\$0	\$0	\$0	-	N/A	Yes
212660201	212660201	1205164928	1205164928	CHARRIC LLC-RICE MEDICAL CENTER	Rural	MSA Central	Rural MSA Central	\$22,325	\$38,962	\$0	\$4,227	193%	Yes
146698701	146698701	1295781227	1295781227	WINNIE COMMUNITY HOSPITAL LLC	Rural	Jefferson	Rural Jefferson	\$7,729	\$19,918	\$0	-	258%	Yes
094117105	094117105	1992707780	1992707780	CASTRO COUNTY HOSPITAL DISTRICT-HANSFORD COUNTY HOSPITAL	Rural	MSA West	Rural MSA West	\$7,751	\$13,101	\$0	\$434	175%	Yes
136142011	136142011	1033118716	1033118716	CASTRO COUNTY HOSPITAL DISTRICT-PLAINS MEMORIAL HOSPITAL	Rural	MSA West	Rural MSA West	\$11,892	\$18,445	\$0	-	155%	Yes
135233809	135233809	1992767511	1992767511	LAVACA MEDICAL CENTER	Rural	MSA Central	Rural MSA Central	\$4,934	\$5,930	\$0	\$2,062	162%	Yes
094180903	094180903	1821066820	1821066820	LYNN COUNTY HOSPITAL-LYNN COUNTY HOSPITAL DISTRICT	Rural	Lubbock	Rural Lubbock	\$15,779	\$8,023	\$0	\$12,077	127%	Yes
152686501	152686501	1780786699	1780786699	PALACIOS COMMUNITY MEDICAL CENTER	Rural	Harris	Rural Harris	\$5,499	\$5,499	\$0	\$8,891	397%	Yes
112702904	112702904	1184607897	1184607897	HASKELL MEMORIAL HOSPITAL	Rural	MSA West	Rural MSA West	\$6,812	\$11,730	\$0	\$5,927	259%	Yes
031189801	031189801	1023015120	1023015120	MILLWOOD HOSPITAL	Non-State-Owned	Tarrant	Non-State-Owned IMD	\$6,812	\$2,548,354	\$0	\$67,679	103%	Yes
13920801	13920801	1013941780	1013941780	COVARIANT LONG TERM CARE LP-COVARIANT SPECIALTY HOSPITAL	IMD	Lubbock	Urban Lubbock	\$3,423,032	\$27,521	\$0	\$38,168	8%	Yes
09238002	09238002	1720279342	1720279342	HEALTHSOUTH REHABILITATION HOSPITAL OF RICHARDSON	Urban	Dallas	Urban Dallas	\$46,434	\$26,350	\$0	\$1,050	139%	Yes
121053601	121053601	1487639175	1487639175	KNOX COUNTY HOSPITAL DISTRICT-KNOX COUNTY HOSPITAL	Rural	MSA West	Urban MSA West	\$0	\$20,946	\$0	-	N/A	Yes
127433308	127433308	1861475626	1861475626	PARKER COUNTY COMMUNITY HOSPITAL	Rural	MSA West	Rural MSA West	\$3,844	\$2,915	\$0	\$52	101%	Yes
339869503	339869503	1184056954	1184056954	ROCK SPRINGS, LLC	IMD	Travis	Non-State-Owned IMD	\$0	\$93,579	\$0	\$30,422	N/A	Yes
121193005	121193005	1538150370	1538150370	SHAMROCK GENERAL HOSPITAL	Rural	MSA West	Rural MSA West	\$0	\$0	\$0	\$1,863	N/A	Yes

112692202	112692202	1598746703	1598746703	FISHER COUNTY HOSPITAL-FISHER COUNTY HOSPITAL DISTRICT	Rural	MSA West	Rural MSA West	\$21,309	\$20,030	\$0	\$	692	110%	Yes
112728403	1083619712	1083619712	1083619712	GENERAL HOSPITAL-IRAN GENERAL HOSPITAL	Rural	MSA West	Rural MSA West	\$0	\$0	\$0	\$	444	N/A	Yes
091770055	091770055	1326025701	1326025701	CONCHO COUNTY HOSPITAL	Rural	MSA West	Rural MSA West	\$0	\$0	\$0	\$	469	N/A	Yes
179727301	140715701	1295764553	1295764553	PREFERRED HOSPITAL LEASING EDORADO INC-SCHLEICHER COUNTY MEDICAL CENTER	Rural	MSA West	Rural MSA West	\$0	\$0	\$0	\$	2,784	N/A	Yes
407628801	09404701	1730183658	1730183658	FISHER COUNTY HOSPITAL DISTRICT-WINKLER COUNTY MEMORIAL HOSPITAL	Rural	MSA West	Rural MSA West	\$0	\$0	\$0	\$	99	N/A	Yes
121060203	121060203	1881697316	1881697316	REAGAN HOSPITAL DISTRICT-REAGAN MEMORIAL HOSPITAL	Rural	MSA West	Rural MSA West	\$0	\$0	\$0	\$	1,911	N/A	Yes
120745806	120745806	1699770149	1699770149	MUENSTER HOSPITAL DISTRICT-MUENSTER MEMORIAL HOSPITAL	Rural	MSA Northeast	Rural MSA Northeast	\$0	\$0	\$0	\$	-	N/A	Yes
173574801	173574801	1245201656	1245201656	TEXAS INSTITUTE FOR SURGERY LLP-TEXAS INSTITUTE FOR SURGERY AT TEXAS HEALTH PRESBY	Urban	Dallas	Urban Dallas	\$0	\$0	\$0	\$	-	N/A	Yes
094382101	094382101	1539264866	1539264866	SETON SHAOL CREEK HOSPITAL	Non-State-Owned IMD	Travis	Urban Dallas	\$72,507	\$93,600	\$0	\$	45,368	126%	Yes
127199806	127199806	1295739258	1295739258	RANKIN COUNTY HOSPITAL DISTRICT	Rural	MSA West	Rural MSA West	\$0	\$0	\$0	\$	120	N/A	Yes
263280001	263280001	1871898478	1871898478	MAYFIELD BEHAVIORAL HEALTH LLC-	Urban	Tarrant	Rural MSA West	\$963,885	\$1,533,301	\$0	\$	-	63%	Yes
088189803	088189803	1356418974	1356418974	THROCKMORTON COUNTY MEMORIAL HOSPITAL-	Urban	MSA West	Urban Tarrant	\$0	\$0	\$0	\$	3	N/A	Yes
133257804	133257804	1841354677	1841354677	SCOTT & WHITE CONTINUING CARE HOSPITAL-BAYLOR SCOTT & WHITE CONTINUING CARE HOSPITAL	Non-State-Owned IMD	Bexar	State-Owned Non-IMD Bexar	\$8,277	\$0	\$0	\$	-	N/A	Yes
388635001	388635001	1013085083	1013085083	CARROLLTON SPRINGS LLC	Urban	MSA Central	Urban MSA Central	\$873	\$64,444	\$0	\$	-	1%	Yes
314330001	314330001	1134401466	1134401466	HOUSTON METHODIST ST CATHERINE HOSPITAL-HOUSTON METHODIST CONTINUING CARE HOSPITAL	Non-State-Owned IMD	Tarrant	Non-State-Owned IMD Tarrant	\$0	\$0	\$0	\$	4,716	N/A	Yes
342897103	342897103	1306268321	1306268321	TEXAS HEALTH SPECIALTY HOSPITAL FORT WORTH-	Urban	Harris	Urban Harris	\$0	\$0	\$0	\$	-	N/A	Yes
094205403	094205403	1730278417	1730278417	THRPB MANAGERY COMPANY LLC-BAYLOR SCOTT AND WHITE THE HEART CENTER	Urban	Tarrant	Urban Tarrant	\$0	\$0	\$0	\$	-	N/A	Yes
330388501	330388501	1194753590	1194753590	TRINITY MEDICAL FRANCES REHABILITATION HOSPITAL-CHRISTUS TRINITY MOTHER FRANCES REHABILITATION HOS	Urban	Tarrant	Urban Tarrant	\$4,479	\$52,143	\$0	\$	-	9%	Yes
184205902	184205902	1316911068	1316911068	HEALTHSOUTH REHABILITATION HOSPITAL THE WOODLANDS-ENCOMPASS HEALTH REHABILITATION HOSPITAL OF THE W	Urban	MSA Northeast	Urban MSA Northeast	\$0	\$14,862	\$0	\$	85,371	574%	Yes
094352403	094352403	1194798801	1194798801	HEALTH REHABILITATION HOSPITAL OF THE W	Urban	Harris	Urban Harris	\$0	\$13,977	\$0	\$	-	0%	Yes
315341301	315341301	1376829812	1376829812	REHABILITATION HOSPITAL OF THE WOODLANDS-ENCOMPASS HEALTH REHABILITATION HOSPITAL OF THE W	Urban	Harris	Urban Harris	\$918	\$16,094	\$0	\$	-	6%	Yes
094349003	094349003	1689648339	1689648339	CNS REHAB OF WF LP-ENCOMPASS HEALTH REHABILITATION HOSPITAL OF WCHIT	Urban	MSA West	Urban MSA West	\$0	\$21,636	\$0	\$	-	0%	Yes
219807201	219807201	1518287721	1518287721	HEALTHSOUTH REHABILITATION HOSPITAL OF SUGAR LAND-HEALTHSOUTH SUGAR LAND REHABILITATION HOSPITAL	Urban	Harris	Urban Harris	\$20,848	\$0	\$0	\$	-	0%	Yes
209804801	209804801	1477731156	1477731156	HEALTHSOUTH REHABILITATION HOSPITAL NORTH HOUSTON-ENCOMPASS HEALTH REHABILITATION HOSPITAL VISION PA	Urban	Harris	Urban Harris	\$0	\$30,483	\$0	\$	-	0%	Yes
327018101	327018101	1366871600	1366871600	HEALTH SOUTH REHABILITATION HOSPITAL OF HUMBLE-	Urban	Harris	Urban Harris	\$37,397	\$56,373	\$0	\$	362,966	971%	Yes
301066801	301066801	1275813610	1275813610	HEALTHSOUTH REHABILITATION HOSPITAL OF CYPRUS LLC-	Urban	Harris	Urban Harris	\$0	\$0	\$0	\$	-	0%	Yes
288662403	288662403	1427374222	1427374222	HEALTHSOUTH REHAB HOSPITAL OF THE MID-CITIES LLC-RELIANT REHABILITATION HOSPITAL MID CITIES	Urban	Tarrant	Urban Tarrant	\$9,217	\$71,327	\$0	\$	-	13%	Yes
189329202	189329202	1699749341	1699749341	HEALTH SOUTH CITYVIEW REHABILITATION HOSPITAL-ENCOMPASS HEALTH SOUTH CITYVIEW REHABILITATION HOSPITAL	Urban	Tarrant	Urban Tarrant	\$62,030	\$134,116	\$0	\$	-	46%	Yes
021172302	021172302	1821062050	1821062050	HEALTHSOUTH REHABILITATION HOSPITAL OF ARLINGTON	Urban	Tarrant	Urban Tarrant	\$121,867	\$243,618	\$0	\$	-	35%	Yes
12762703	12762703	1073511762	1073511762	BAYLOR MED CTR AT GRAPEVINE-BAYLOR SCOTT AND WHITE MEDICAL CENTER-GRAPEVINE	Urban	Tarrant	Urban Tarrant	\$524,566	\$3,358,919	\$0	\$	-	16%	Yes
133331202	133331202	1942218581	1942218581	Texas HMSC Rusk State Hospital	State-Owned IMD	MSA Northeast	State-Owned IMD MSA Northeast	\$0	\$0	\$0	\$	-	N/A	Yes
137918204	137918204	1881600682	1881600682	Texas HMSC Big Spring State Hospital	State-Owned IMD	MSA West	State-Owned IMD MSA West	\$0	\$0	\$0	\$	-	N/A	Yes
127220302	127220302	1407862170	1407862170	Texas HMSC Kerrville State Hospital	State-Owned IMD	MSA West	State-Owned IMD MSA West	\$0	\$0	\$0	\$	-	N/A	Yes
139487601	139487601	1366880627	1366880627	MSA SPRINGS, LLC-	State-Owned IMD	MSA West	State-Owned IMD MSA West	\$0	\$0	\$0	\$	-	N/A	Yes
415930301	351415001	1285258640	1285258640	Kindred BH Acquisition 1, LLC d/b/a WellBridge Hospital Greater Dallas	Non-State-Owned IMD	Tarrant	Non-State-Owned IMD Tarrant	\$54,838	\$1,220,613	\$0	\$	-	N/A	Yes
414962701	414962701	1942795133	1942795133	Kindred BH Acquisition 2, LLC d/b/a WellBridge Healthcare Fort Worth	Non-State-Owned IMD	Tarrant	Non-State-Owned IMD Tarrant	\$0	\$0	\$0	\$	-	N/A	Yes
400811201	400811201	1346724879	1346724879	Ascension Seton Baptist	Non-State-Owned IMD	Tarrant	Non-State-Owned IMD Tarrant	\$3,707	\$0	\$0	\$	-	N/A	Yes
414763901	414763901	1104381292	1104381292	El Paso Behavioral Health, LLC DBA Rio Vista Behavioral Health	Non-State-Owned IMD	El Paso	State-owned IMD El Paso	\$20,999	\$21,644	\$0	\$	59,237	371%	Yes
382091201	382091201	1144765578	1144765578	Texas Health Fresco	Urban	Dallas	Urban Dallas	\$0	\$0	\$0	\$	-	N/A	Yes
413256501	413256501	1356960132	1356960132	Encompass Health Rehabilitation Hospital of Pearland	Urban	Harris	Urban Harris	\$0	\$0	\$0	\$	-	N/A	Yes
413256501	413256501	1356960132	1356960132	South Plains Rehabilitation Hospital, an affiliate of UMC and Encompass Health	Urban	Lubbock	Urban Lubbock	\$0	\$0	\$0	\$	-	N/A	Yes
413256501	413256501	1356960132	1356960132	Texas Health Rehabilitation Hospital of Dallas	Urban	Lubbock	Urban Lubbock	\$0	\$0	\$0	\$	-	N/A	Yes
413256501	413256501	1356960132	1356960132	Texas Health Rehabilitation Hospital of Dallas	Urban	Dallas	Urban Dallas	\$0	\$0	\$0	\$	-	N/A	Yes
413256501	413256501	1356960132	1356960132	Methodist Multisite Medical Center	Urban	Dallas	Urban Dallas	\$0	\$0	\$0	\$	-	N/A	Yes
409579001	409579001	1679526682	1679526682	MENDRICK MEDICAL CENTER BROWNWOOD	Rural	MSA West	Rural MSA West	\$2,578,071	\$0	\$0	\$	116,171	N/A	Yes
407926101	407926101	1144781501	1144781501	BAYLOR SCOTT & WHITE MEDICAL CENTERS - CAPITOL AREA	Urban	Travis	Urban Travis	\$0	\$0	\$0	\$	-	N/A	Yes
219326001	219326001	1861690364	1861690364	DALLAS MEDICAL CENTER, LLC-	Urban	Dallas	Urban Dallas	\$1,187,714	\$1,528,447	\$0	\$	2,179	N/A	Yes
315403001	315403001	1780628184	1780628184	TEXAS SCOTTISH RITE HOSPITAL FOR CRIPPLED CHILDREN-	Children's	Dallas	Children's Dallas	\$3,338,718	\$4,247,438	\$0	\$	2,154,641	140%	Yes
348228801	348228801	1679903967	1679903967	Baylor Scott & White Emergency Hospital Burleson	Urban	Tarrant	Urban Tarrant	\$39,493	\$53,711	\$0	\$	-	47%	Yes

**Texas & CMS Meeting: Friday, August 20, 2021****Discussion: State Directed Payment Preprint Modifications**

CMS is committed to working with Texas to support safety net providers and to ensure that safety net financing and reimbursement approaches advance measurement and accountability for improving health equity and quality. We reiterate our offer, outlined in CMS' August 13, 2021 letter, to address the near-term stability for safety net providers while CMS and Texas continue to work toward a more sustainable, equitable, and high quality safety net, by approving an amendment to the state's demonstration, if timely submitted, that would extend the DSRIP program for one year (through September 30, 2022).

At the state's request, CMS is providing, in the chart below, more detailed information under Option 2, which was outlined in the Appendix to the August 13, 2021 letter. As described below, the state could modify all five (5) state directed payment preprints currently under CMS review for SFY 2022 to be consistent with statutory and regulatory requirements. Such modifications will need to satisfy all the terms below, with sufficient data to CMS as described. Most importantly, the state will need to ensure that the overall aggregate amount of payments is significantly less than previously proposed to satisfy actuarial concerns.

CMS will review the information submitted by the state, which may lead to additional communications back and forth between the state and CMS.

As an alternative, the state could resubmit the preprints as described in option 1, and CMS could timely approve those preprints before September 1, 2021.

In either case, CMS is willing to work with the state on the extension of DSRIP, subject to the state's submission of an amendment, consistent with the STCs in the THTQP demonstration by Monday, August 23.

CMS will work with the state over the course of the next year on a more sustainable approach to a high-quality, equitable health safety net.

<b>State Directed Payment Topic</b>	<b>Modifications/Information Required for State Fiscal Year (SFY) 2022 Under Option #2</b>
Quality Incentive Payment Program (QIPP)	<p>1. Remove the 18% reconciliation threshold on component 1 and base payments only on current utilization or performance measured during the contract rating period (rather than historical utilization or performance).</p> <p><b>State Response:</b> Texas has utilized this type of program structure since the inception of QIPP in 2017. CMS noted in the SFY 2021 program approval: "if the state continues to pay this component as a uniform increase, CMS expects the state to move away from a reconciliation requirement and instead require plans to pay based on the actual facility bed days during the contract rating period." Texas understood this guidance to indicate that efforts should be made to show progress prior to the SFY 2022 submission, but did not understand CMS to be stating that the state must definitively eliminate this structure prior</p>

to SFY 2022. As CMS is aware, nursing facility providers have undergone tremendous strain since the beginning of the public health emergency as they have worked to respond to COVID-19. For that reason, Texas did not undertake major structural changes to QIPP for SFY 2022, except for continuing advancements in our quality goals. To that end, the state has enhanced Component 1 to require a PIP with documented progress on the PIP, which we believe is a considerable advance towards a more performance-based payment. With respect to the existing reconciliation threshold, our preliminary review of QIPP Year 4 data suggests a likelihood of a reconciliation required following the program period. The state considers claims to be adjudicated 180 days following the date of encounter and these numbers are subject to change, but the state would like to emphasize that the potential impact of COVID-19 on utilization is not yet known, and the state believes the threshold is appropriate for QIPP Year 5.

However, Texas also believes that the necessity of the continuation of this program for SFY 2022 is critical to the quality of services delivered to the Medicaid nursing facility beneficiaries. We understand from the call between Texas and CMS on August 20, 2021, CMS will not consider Texas's proposal of a reduced threshold for SFY 2022, with a complete elimination of the structure for SFY2023. In an effort to achieve a pathway forward for this important and long-standing program, Texas would like to utilize a payment structure where interim payments for SFY 2022 are based initially upon the historical utilization data, with final payments made based upon actual data at the end of the program year, with no contingency for a variation in utilization data. This approach will allow for consistent payments to be made through the program year, but final payments to be based exclusively on actual utilization. Would CMS agree that this approach resolves any outstanding concerns about the tie to utilization? If so, Texas will submit a revised pre-print to this effect immediately.

2. Require that any payments based on performance are made only for facilities that achieve year over year improvement in accordance with the regulatory requirement that the arrangement must advance managed care quality goals and objectives.

**State Response:** MDS-based quality measures in Component 3 include improvement-over-self-targets as well as program-wide targets. As indicated in the pre-print Q&A, program-wide targets are meant to incentivize the participation of smaller facilities, where natural population fluctuations lead to wider variance in quarterly performance tracking, and already high-performing facilities, where there is less room for sustained improvement-over-self.

- a. Does CMS recommend HHSC remove quarterly measurement cycles and rely only on averaged or annual improvement for all participating facilities?

	<p>b. Does CMS expect the state to select one year as the baseline for that program year and subsequent years (e.g. FY 2021 baseline would be used not only to evaluate FY 2022, but also FY 2023, 2024, etc.) or can the baseline be set at the start of each program year (the method used in QIPP since year 1)?</p> <p>c. Would CMS consider SDPs with performance-based components that use structure or process measures, or are outcome measures the only acceptable type of measures? For example, QIPP Component 2 recognizes increased nurse hours.</p> <p>3. Refine the evaluation plan for QIPP to ensure that the effect of the QIPP state directed payment, absent other programmatic changes or other state directed payments, can be appropriately evaluated by the state, including a sound attribution methodology. The state must provide consistent baseline data to demonstrate year over year changes.</p> <p><b>State Response:</b> It is the state's goal to have improvement year over year and to evaluate annual performance for participating facilities. The QIPP Performance Review submitted with the SFY 2022 pre-print includes analyses of the first three program years and demonstrated year-over-year improvement. Likewise, the QIPP Evaluation Plan submitted with the SFY 2022 pre-print includes a methodology of analysis that measures participating facilities individually and as a group against previous year performance. Some individual, MCO-designed value-based payment agreements with individual nursing facilities (NFs) may exist but QIPP is the only state-wide payment program focusing on NFs. For structure and process performance measures, the state planned to use SFY 2022 data as a baseline for future years.</p> <p>a. Does CMS have specific recommendations for how to isolate the impact of DPP from other state-wide initiatives?</p>
Comprehensive Hospital Increase Reimbursement Program (CHIRP)	<p>1. CMS does not consider the current aggregate payment amounts to be reasonable and appropriate, and CMS is concerned that the resulting capitation rates are not actuarially sound. Additionally, the state must provide a complete reimbursement analysis with a comparison to the average commercial rate for hospitals that only participate in the UHRIP component of the state directed payment. This reimbursement analysis must include hospital-specific reimbursement data as compared to the average commercial rate by hospital for the hospitals participating only in the UHRIP component.</p> <p><b>State Response:</b></p> <p>Aggregate Payment Amounts:</p>



Texas understands that CMS has approved directed-payment programs in other states using a comparison to the estimate of what an average commercial payor would have paid for the same services. To develop an estimate of an ACR upper payment limit, in consultation with CMS, Texas designed CHIRP to utilize a payment-to-charge ratio that is identical to the method used to calculate the estimate of Medicare payments for the same services. Texas understands from its call with CMS on August 20, 2021 that the proposed CHIRP would be the largest payment by gross dollars approved by CMS and that the year-over-year increase from FY2021 UHRIP to the proposed FY2022 CHIRP is a significant percentage increase.

Texas notes that Medicaid generally requires reimbursement rates to be economic and efficient, but sufficient to attract enough providers for a Medicaid beneficiary to have equivalent access to a provider as an individual who is not in the Medicaid program. Because of this, reimbursement rates on a per service or per provider basis are generally understood to consider comparators to determine a reasonable and appropriate level of reimbursement. On Texas' call with CMS on August 24, 2021, CMS confirmed that typical comparators examined to evaluate reasonableness include Medicare, average commercial rates, and Medicaid Fee-for-service. We indicated that in Texas Medicaid FFS represents less than 4% of our population and for that reason, we feel that a more appropriate comparator is either Medicare or Average Commercial. CMS also noted that there may be variation in appropriateness of payment amongst payers for a variety of reasons; Texas agrees, specifically as it relates to Medicare. Texas' Medicaid population is primarily children and pregnant women who are not typical Medicare populations. For this reason for hospitals in Texas, such as Children's hospitals, or urban hospitals that have high levels of maternity and neonatal care, Medicare may not be the most appropriate comparator and average commercial is likely the most appropriate comparator.

Additionally, as discussed on the August 24, 2021 call, reimbursement rates generally incorporate some contemplation of the aspects of the provider market. As CMS is aware, with the discontinuation of DSRIP in FY2022, hospital payments in Texas will decline by more than \$1.6 billion. Inherently, this means that the provider market, including willingness to serve Medicaid clients at prior rates, will not be comparable between FY2021 and FY2022. For this reason, Texas does not believe a year-over-year comparison of aggregate Medicaid managed care costs is appropriate.

#### Actuarial Soundness of Capitation Rates:

It has been Texas's long-standing understanding that actuarial soundness practices and principles for setting capitation rates applies to providing reasonable and appropriate provision to Managed Care Organizations congruent with costs and risk under the contracts. HHSC submitted actuarial certification reports to CMS on July 16, 2021 that included the CHIRP add-on



rates for FY 2022. The actuarial opinion outlines the actuarial practices and principles applied to arrive at actuarially sound rates for the inclusion of the CHIRP, should CMS approve the program as submitted. In recent discussions, CMS is also applying actuarial opinions to aggregate Medicaid managed care spending. HHSC is not aware of federal guidance or direction for the actuary to provide an opinion on provider rates nor aggregate spending.

In the August 24, 2021 call, CMS clarified that the review by OACT was made in the context of the pre-print review, and not the evaluation of the capitated rate submission. CMS further clarified that the questions and concerns at this time were more focused on the reasonableness of the underlying provider reimbursements and were not regarding the actuarial soundness of the capitated rates. Texas appreciates this clarification and agrees that there are not currently actuarial soundness concerns with the calculated capitated rates.

#### Reimbursement Analysis:

Texas also understands that CMS typically analyzes the reasonableness of the impact of state-directed payments on a per class basis, rather than on an individual provider basis, as illustrated in the pre-print template question 23. CMS confirmed this understanding on the August 24, 2021 call. Texas is of course willing to provide to CMS an analysis of the individual hospitals that are UHRIP participants only, for those providers who furnished to Texas the data necessary to calculate an ACR UPL. Please find it attached in Attachment A. Texas did not receive ACR data in the application from 17 hospitals, as providing such data was optional for providers at the time of the application. Texas seeks CMS guidance on whether CMS would allow Texas to obtain the data from these providers within 4 months of the program effective date with the condition that if the data is not received in that time frame, these providers would be removed from CHIRP, or alternately whether these providers can merely be restricted from participation in ACIA, as was originally planned. Texas would be willing to seek the data from the providers and furnish it to CMS as part of the monthly ongoing oversight calls that are supposed to occur between CMS and Texas pursuant to STC 36.

#### Next Steps:

While Texas continues to believe that the initial proposal and the underlying provider reimbursements on a per class basis are reasonable and appropriate, Texas would like to work with CMS collaboratively to achieve an approval for SFY 2022. Texas would be willing to impose a cap of 90% on the aggregate percentage of ACR that a hospital class can receive. This would reduce the total estimated program size to approximately \$4.7 billion and would ensure that on an aggregate class basis, payments are at least 10% lower than ACR. Would CMS agree that this approach resolves any outstanding concerns about reasonableness of the payments and actuarial soundness? While the ACR data from 17 providers would be absent for this methodology based upon the data we have, they would be represented in the aggregate calculation as having an

ACR UPL of \$0 and thus their inclusion would have the effect of creating a lower aggregate ACR UPL cap because there would be no amount included in the denominator, though these providers would be included in the numerator. If so, Texas will submit a revised pre-print to this effect immediately.

2. Refine the evaluation plan for CHIRP to ensure that the effect of the CHIRP state directed payment, absent other programmatic changes or other state directed payments, can be appropriately evaluated by the state, including a sound attribution methodology. The state must provide consistent baseline data to demonstrate year over year changes.

**State Response:** The state is working with our EQRO contractor to refine an attribution methodology for each program. There are some measures included in the evaluation which cannot be limited to providers participating in the DPP. Some of the measures that cannot be attributed exclusively to one DPP provider are CMS core set measures recommended by CMS for DPP evaluations. In light of the call on 8/24 and CMS' acknowledgement, we will proceed with maintaining the CMS core set measures selected for the respective evaluations, even though they cannot be attributed only to providers participating in the corresponding DPPs. HHSC is also open to providing one annual DPP evaluation which breaks out DPP-specific attribution measures, as suggested by CMS in the August 24, 2021 call with Texas.

- a. Does CMS have any other recommendations for how to isolate the impact of the DPP other than the work HHSC is undertaking with its EQRO contractor to do so?

With respect to baseline year, in a phone call on January 27, 2021 with CMS, HHSC proposed using CY 2020 and CY2021 as baselines because of the timing of the beginning of the program (CY 2021 would include 4 months of the start of the program) and the impact of COVID. Using the two years was intended to capture that context for future measurement. CMS indicated the proposal made sense. If CMS prefers that we use only one year, HHSC could use CY 2021 for the new CHIRP evaluation measures. However, this would delay further any evaluation of the programs because of data lags (please see page 6 of the CHIRP updated evaluation plan for timeline of available data).

With respect to year-over-year improvement, it is the state's goal to have improvement year-over-year, but we are also cognizant of not being able to set goals at this point because of the unknown impact of the PHE.

- a. Does CMS have a recommendation for how the state can address this issue in the evaluation plan?
- b. Would maintenance of a high-performance rate within an allowable threshold (but still above national benchmarks, for example) be acceptable?

<p>Texas Incentives for Physicians and Professional Services (TIPPS)</p>	<ol style="list-style-type: none"> <li>1. Remove the 18% reconciliation threshold and base payments only on current utilization or performance measured during the rating period (rather than historical utilization or performance).</li> </ol> <p><b>State Response:</b> We understand from the call between Texas and CMS on August 20, 2021, CMS will not consider Texas’s proposal of a reduced threshold for SFY 2022, with a complete elimination of the structure for SFY2023. In an effort to achieve a pathway forward for this important program, Texas would like to utilize a payment structure where interim payments for SFY 2022 are based initially upon the historical utilization data, with final payments made based upon actual data at the end of the program year, with no contingency for a variation in utilization data. This approach will allow for consistent payments to be made through the program year, but final payments to be based exclusively on actual utilization. Would CMS agree that this approach resolves any outstanding concerns about the tie to utilization? If so, Texas will submit a revised pre-print to this effect immediately.</p> <li>2. Require that any payments be based on performance linked to Medicaid managed care enrollees only (not Medicaid FFS), and performance-based payments must ensure that providers are achieving year over year improvement in accordance with the regulatory requirement that the arrangement must advance managed care quality goals and objectives.</li> <p><b>State Response:</b> The state believes the payments are based on performance linked to Medicaid managed care enrollees. HHSC has developed a hybrid model that requires providers to meet program quality requirements, but where payment is still triggered by Medicaid managed care utilization. In the TIPPS amended pre-print, both types of DPPs are selected in question 9. For example, in the TIPPS Component 3 and DPP BHS Component 2, once a provider has demonstrated achievement on their measures, they are eligible to earn payments. The payments are rate enhancements paid upon claims adjudication of certain codes identified in the program requirements. On the August 24, 2021 call with Texas, CMS indicated this was not clear in the preprint. Could we maintain the quality descriptions in our pre-print submissions, as we hope to transition toward more value-based DPPs in the future, but change the selection under question 10 to remove “Quality Payment/Pay for Performance” but leave “Medicaid-Specific Delivery System Reform” and “Performance Improvement Initiative”? Or does CMS have suggestions for other changes Texas could make to the pre-print to address this issue?</p> <p>Should CMS want to restrict measurement to only Medicaid managed care members, would it be possible to transition over the first year of the program so that providers are able to make necessary system changes to stratify by Medicaid managed care only? In that instance, HHSC would need to amend the</p>
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selection of measures used for tracking provider quality improvement, such as the structure measures or hospital safety measures.

- a. Does CMS's concern about restricting measurement to managed care members only apply to Pay-for-performance measures in a value-based DPP? Or would it also apply to provider-reported measures used for evaluations?

With regard to year-over-year improvement, we also have additional questions:

- b. HHSC assumes this applies to provider-level pay-for-performance measures in addition to evaluation measurement at the Medicaid-member level. Is that correct?
  - c. How should this apply to structure measures currently included in the program?
  - d. Texas DPPs feature measures intended exclusively as improvement over self (IOS) measures or benchmark measures. If a measure is exclusively a benchmark measure, is it acceptable for a provider to maintain performance above the benchmark?
  - e. Would maintenance of a rate of performance for a high performer be acceptable?
3. Refine the evaluation plan for TIPPS to ensure that the effect of the TIPPS state directed payment, absent other programmatic changes or other state directed payments, can be appropriately evaluated by the state, including a sound attribution methodology. The state must provide consistent baseline data to demonstrate year over year changes.

**State Response:** The state is working with our EQRO contractor to refine an attribution methodology for each program. There are some measures included in the evaluation which cannot be limited to providers participating in the DPP. Some of the measures that cannot be attributed exclusively to one DPP provider are CMS core set measures recommended by CMS for DPP evaluations. In light of the call with Texas on August 24 and CMS' acknowledgement, we will proceed with maintaining the CMS core set measures selected for the respective evaluations, even though they cannot be attributed only to providers participating in the corresponding DPPs. HHSC is also open to providing one annual DPP evaluation which breaks out DPP-specific attribution measures, as suggested by CMS in the August 24, 2021 call with Texas.

- b. Does CMS have any other recommendations for how to isolate the impact of the DPP other than the work HHSC is undertaking with its contractor to do so?

With respect to baseline year, in a phone call on January 27, 2021 with CMS, HHSC proposed using CY 2020 and CY2021 as baselines because of the timing of the beginning of the program (CY 2021 would include 4 months of

	<p>the start of the program) and the impact of COVID. Using the two years was intended to capture that context for future measurement. CMS indicated the proposal made sense. If CMS prefers that we use only one year, HHSC could use CY 2021 for the new TIPPS evaluation measures. However, this would delay further any evaluation of the programs because of data lags (please see page 5 of the TIPPS updated evaluation plan for timeline of available data).</p> <p>With respect to year-over-year improvement, it is the state's goal to have improvement year-over-year, but we are also cognizant of not being able to set goals at this point because of the unknown impact of the PHE.</p> <ul style="list-style-type: none"> <li>c. Does CMS have a recommendation for how the state can address this issue in the evaluation plan?</li> <li>d. Would maintenance of a high-performance rate within an allowable threshold (but still above national benchmarks, for example) be acceptable?</li> </ul>
Rural Access to Primary and Preventative Services (RAPPS)	<ol style="list-style-type: none"> <li>1. Remove the 10% reconciliation threshold and base payments only on current utilization or performance measured during the rating period (rather than historical utilization or performance).</li> </ol> <p><b>State Response:</b> We understand from the call between Texas and CMS on August 20, 2021, CMS will not consider Texas's proposal of a reduced threshold for SFY 2022, with a complete elimination of the structure for SFY2023. In an effort to achieve a pathway forward for this important program, Texas would like to utilize a payment structure where interim payments for SFY 2022 are based initially upon the historical utilization data, with final payments made based upon actual data at the end of the program year, with no contingency for a variation in utilization data. This approach will allow for consistent payments to be made through the program year, but final payments to be based exclusively on actual utilization. Would CMS agree that this approach resolves any outstanding concerns about the tie to utilization? If so, Texas will submit a revised pre-print to this effect immediately.</p> <ol style="list-style-type: none"> <li>2. Refine the evaluation plan for RAPPS to ensure that the effect of the RAPPS state directed payment, absent other programmatic changes or other state directed payments, can be appropriately evaluated by the state, including a sound attribution methodology. The state must provide consistent baseline data to demonstrate year over year changes.</li> </ol> <p><b>State Response:</b> The state is working with our EQRO contractor to refine an attribution methodology for each program. There are some measures included in the evaluation which cannot be limited to providers participating in the DPP. Some of the measures that cannot be attributed exclusively to one DPP provider are CMS core set measures recommended by CMS for DPP evaluations. In light of the call with Texas on August 24 and CMS' acknowledgement, we will proceed with maintaining the CMS core set</p>

	<p>measures selected for the respective evaluations, even though they cannot be attributed only to providers participating in the corresponding DPPs. HHSC is also open to providing one annual DPP evaluation which breaks out DPP-specific attribution measures, as suggested by CMS in the August 24, 2021 call with Texas.</p> <p>c. Does CMS have any other recommendations for how to isolate the impact of the DPP other than the work HHSC is undertaking with its contractor to do so?</p> <p>With respect to baseline year, in a phone call on January 27, 2021 with CMS, HHSC proposed using CY 2020 and CY2021 as baselines because of the timing of the beginning of the program (CY 2021 would include 4 months of the start of the program) and the impact of COVID. Using the two years was intended to capture that context for future measurement. CMS indicated the proposal made sense. If CMS prefers that we use only one year, HHSC could use CY 2021 for the new RAPPs evaluation measures. However, this would delay further any evaluation of the programs because of data lags (please see page 5 of the RAPPs updated evaluation plan for timeline of available data).</p> <p>With respect to year-over-year improvement, it is the state's goal to have improvement year-over-year, but we are also cognizant of not being able to set goals at this point because of the unknown impact of the PHE.</p> <p>e. Does CMS have a recommendation for how the state can address this issue in the evaluation plan?</p> <p>f. Would maintenance of a high-performance rate within an allowable threshold (but still above national benchmarks, for example) be acceptable?</p>
Behavioral Health Services Directed Payment Program (BHS)	<p>1. Remove the 10% reconciliation threshold and base payments only on current utilization or performance measured during the rating period (rather than historical utilization or performance).</p> <p><b>State Response:</b> We understand from the call between Texas and CMS on August 20, 2021, CMS will not consider Texas's proposal of a reduced threshold for SFY 2022, with a complete elimination of the structure for SFY2023. In an effort to achieve a pathway forward for this important program, Texas would like to utilize a payment structure where interim payments for SFY 2022 are based initially upon the historical utilization data, with final payments made based upon actual data at the end of the program year, with no contingency for a variation in utilization data. This approach will allow for consistent payments to be made through the program year, but final payments to be based exclusively on actual utilization. Would CMS agree that this approach resolves any outstanding concerns about the tie to utilization? If so, Texas will submit a revised pre-print to this effect immediately.</p>



2. Require that any payments be based on performance linked to Medicaid managed care enrollees only (not Medicaid FFS), and performance-based payments must ensure that providers are achieving year over year improvement in accordance with the regulatory requirement that the arrangement must advance managed care quality goals and objectives.

**State Response:** The state believes the payments are based on performance linked to Medicaid managed care enrollees. HHSC has developed a hybrid model that requires providers to meet program quality requirements, but where payment is still triggered by Medicaid managed care utilization. For example, in the TIPPS Component 3 and DPP BHS Component 2, once a provider has demonstrated achievement on their measures, they are eligible to earn payments. The payments are rate enhancements paid upon claims adjudication of certain codes identified in the program requirements. On the August 24, 2021 call with Texas, CMS indicated this was not clear in the preprint. Could we maintain the quality descriptions in our pre-print submissions, as we hope to transition toward more value-based DPPs in the future, but change the selection under question 10 to remove “Quality Payment/Pay for Performance” but leave “Medicaid-Specific Delivery System Reform” and “Performance Improvement Initiative”? Or does CMS have suggestions for other changes Texas could make to the pre-print to address this issue?

Should CMS want to restrict measurement to only Medicaid managed care members, HHSC would propose to transition over the first year of the program so that providers are able to make necessary system changes to stratify by Medicaid managed care only, and HHSC would need to amend the selection of measures used for tracking provider quality improvement, such as the structure measures or hospital safety measures.

- f. Is this a requirement that only applies to Pay-for-performance measures in a value-based DPP? Or would it also apply to provider-reported measures used for evaluations?

With regard to year-over-year improvement

- a. HHSC assumes this applies to provider-level pay-for-performance measures in addition to evaluation measurement at the Medicaid-member level. Is that correct?
- b. How should this apply to structure measures currently included in the program?
- c. Texas DPPs feature measures intended exclusively as improvement over self (IOS) measures or benchmark measures. If a measure is exclusively a benchmark measure, is it not acceptable for a provider to maintain performance above the benchmark?
- d. Would maintenance of a rate of performance for a high performer be acceptable?

	<p>3. Refine the evaluation plan for BHS to ensure that the effect of the BHS state directed payment, absent other programmatic changes or other state directed payments, can be appropriately evaluated by the state, including a sound attribution methodology. The state must provide consistent baseline data to demonstrate year over year changes.</p> <p><b>State Response:</b> The state is working with our EQRO contractor to refine an attribution methodology for each program. There are some measures included in the evaluation which cannot be limited to providers participating in the DPP. Some of the measures that cannot be attributed exclusively to one DPP provider are CMS core set measures recommended by CMS for DPP evaluations. In light of the call with Texas on August 24 and CMS' acknowledgement, we will proceed with maintaining the CMS core set measures selected for the respective evaluations, even though they cannot be attributed only to providers participating in the corresponding DPPs. HHSC is open to providing one annual DPP evaluation which breaks out DPP-specific attribution measures, as CMS suggested in the August 24, 2021 call with Texas.</p> <p>d. Does CMS have any other recommendations for how to isolate the impact of the DPP other than the work HHSC is undertaking with its contractor to do so?</p> <p>With respect to baseline year, in a phone call on January 27, 2021 with CMS, HHSC proposed using CY 2020 and CY2021 as baselines because of the timing of the beginning of the program (CY 2021 would include 4 months of the start of the program) and the impact of COVID. Using the two years was intended to capture that context for future measurement. CMS indicated the proposal made sense. If CMS prefers that we use only one year, HHSC could use CY 2021 for the new DPP BHS evaluation measures. However, this would delay further any evaluation of the programs because of data lags (please see page 4-5 of the DPP BHS updated evaluation plan for timeline of available data).</p> <p>With respect to year-over-year improvement, it is the state's goal to have improvement year-over-year, but we are also cognizant of not being able to set goals at this point because of the unknown impact of the PHE.</p> <p>g. Does CMS have a recommendation for how the state can address this issue in the evaluation plan?</p> <p>h. Would maintenance of a high-performance rate within an allowable threshold (but still above national benchmarks, for example) be acceptable?</p>
Sources of Non-Federal Share (IGTs, Bonds,	CMS and the state must ensure that sources of non-federal share (including bond revenues, and other debt instruments, that localities use to source inter-governmental transfers) comply with section 1903(w) of the Social Security Act and implementing regulations at 42 CFR Part 433.



and Debt Instruments)	<p>1. Please confirm that Texas currently does not collect information related to the entities that purchase bonds (and other debt instruments) that are used to finance the non-federal share of Medicaid payments from localities that provide inter-governmental transfers.</p> <p><b>State Response:</b> Texas confirms this statement.</p> <p>2. Please provide an assurance that Texas will develop an oversight plan for local non-federal share financing, whereby the state will collect and maintain information from localities detailing (at a minimum):</p> <ol style="list-style-type: none"> <li>The names of entities that purchase bonds (or other debt instruments) used to finance the non-federal share of Medicaid payments.</li> <li>Identification of any providers or provider-related organizations that are bond (or other debt instruments) purchasers.</li> <li>Identification of any providers or provider-related organizations that are bond (or other debt instruments) purchasers and that either: receive Medicaid payments directly or are within a provider class that receives Medicaid payments.</li> <li>For any entity identified under (c), the total dollar amount of the bonds (or other debt instruments) the entity purchases and the amount of Medicaid payments the entity (or provider class) receives.</li> </ol> <p><b>State Response:</b> Texas is developing a comprehensive monitoring and oversight plan for local funds used in the Medicaid program. To the extent that a local or state governmental entity is in possession of information about bond purchasers (or other debt instruments), Texas would be willing to obtain and provide this information to CMS. However, as discussed on the August 20, 2021 call between Texas and CMS, Texas is unsure that governmental entities that have bonds issued by an underwriter or financial institution who sells the bonds through a normal bond market would be in possession of this information. As a result, Texas requests that CMS provide to Texas for use in the development of the oversight plan:</p> <ol style="list-style-type: none"> <li>(1) a clear description of the circumstances in which the information sought above is required (I.e. for all bond offerings by a governmental entity or only for a bond issued for specific purposes);</li> <li>(2) a clear description of an exemption to the requirement of providing this language if a governmental entity can attest that they are not in possession of and have no knowledge of who has purchased the bonds, if the bonds are available for purchase to the general public through a routine bond issuing transaction; and</li> <li>(3) clarity on how frequent this reporting would be due.</li> </ol> <p>3. CMS understands that the state is in the process of setting up an oversight group related to the financing mechanisms described in this state directed payment preprint. Please describe steps in the near-term that the state will</p>
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	<p>use to effectively oversee how these program payments are funded by the state or local units of governments.</p> <p><b>State Response:</b> S.B. 1 (Article II, Health and Human Services Commission, Rider 15), 87<sup>th</sup> Texas Legislature, Regular Session, 2021, authorizes additional staff to HHSC for increased monitoring and oversight of the use of local funds and the administration of new directed-payment programs. Texas plans to utilize the resources to implement additional oversight and monitoring as described in Attachment B.</p>
Sources of Non-Federal Share (Locality Taxes and LPPFs)	<p>To ensure compliance with section 1903(w)(4) of the Social Security Act and implementing regulations in 42 CFR 433.68(f)(3), please provide the following:</p> <ol style="list-style-type: none"> <li>1. A table using the most recent data available to the State, of every LPPF in the State, including the name of the unit of local government that operates the LPPF, the hospitals that are taxed in the LPPF, and the amount that each hospital is taxed, and the amount of payments funded by the tax.</li> </ol> <p><b>State Report:</b> Please see Attachment C, which is the most recent final data we have at this time.</p> <ol style="list-style-type: none"> <li>2. Written attestation from the state that: <ol style="list-style-type: none"> <li>a. No localities impose a tax where all hospitals paying the tax receive their total tax cost back in the form of Medicaid payments funded by the tax (including localities that impose a tax on a single hospital).</li> <li>b. No localities impose a tax on hospitals that are not located within the boundaries of their jurisdiction.</li> <li>c. That the state will actively oversee how the locality taxes and LPPF arrangements meet federal requirements on an ongoing basis.</li> </ol> </li> </ol> <p><b>State Response:</b> The state attests that the above is true and accurate. With respect to item (2)(c), HHSC clarifies that HHSC does not have regulatory authority over nor oversees the operation of any LPPF. As a result, HHSC is limited to actively overseeing the arrangements for the specific and exclusive determination that the revenues transferred to HHSC for use in the Medicaid program meet applicable state and federal requirements for using funds in the Medicaid program.</p> <ol style="list-style-type: none"> <li>3. Written attestations from all participating hospitals that they do not participate in arrangements, through written agreements or otherwise, which involve participating hospitals transferring, redirecting, redistributing (including through pooling arrangements) Medicaid payments to other Medicaid providers, directly or indirectly.</li> </ol> <p><b>State Response:</b> The state takes seriously its responsibility to ensure compliance with all federal financing requirements. In compliance with the relevant statute and CMS's published rulemaking and state reporting</p>

	<p>requirements, the state has implemented an LPPF monitoring requirement to ensure that units of local government with authority to operate an LPPF do not have any statutes, regulations, or policies that could constitute such a guarantee. However, it must be noted that the law CMS purports to be enforcing refers to arrangements in which the State or other unit of government imposing the tax provides for any payment that guarantees to hold taxpayers harmless. As CMS explained in its February 2008 final rule, “the element necessary to constitute a direct guarantee is the provision for payment by State statute, regulation, or policy.” 73 Fed. Reg. 9694. Neither § 1903(w)(4) nor § 433.68(f)(3) give CMS the authority to regulate (or to require States to regulate) transactions between private providers in which the State is not involved. Therefore, Texas requests that CMS clarify the following:</p> <p>(1) Given that CMS withdrew the proposed rule that would have expanded the circumstances in which a direct guarantee will be found to exist, what is CMS’s legal authority for finding a direct guarantee when a governmental entity is not a party to the arrangement?</p> <p>(2) Can CMS provide the statute or regulation that specifically restricts or directs how a Medicaid provider may use reimbursements received for services delivered in the Medicaid program once received by the provider?</p>
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#### Texas Budget Neutrality (BN) Implications Questions on State Directed Payments (SDPs)

- Texas has asked about the budget neutrality (BN) implications for the next year of the demonstration.
- CMS’ offer to extend DSRIP is intended to help provide stability over the next year while we continue to work on the SDPs and other approaches to secure the safety net.
- Under current BN policy, the DSRIP expenditures would be authorized as a cost not otherwise matchable (CNOM) and would be reflected on the “with waiver (WW)” side of budget neutrality for the coming year. In applying the rebasing policy, as articulated in STC 62, CNOM are not included in the without waiver (WOW) baseline.
- The state has adequate savings to absorb these additional DSRIP expenditures for the next demonstration year.
- CMS recognizes the importance of and shares Texas’s commitment to maintaining a sustainable approach to safety net hospital reimbursement. The one year DSRIP extension provides an opportunity for CMS and Texas to continue to work toward a more sustainable, equitable, and high quality safety net.

## Attachment B – Oversight and Monitoring Plan for Local Funds Used in Medicaid in Texas

### Background:

For the Texas State Fiscal Year 2020, Texas Health and Human Services system published the Blueprint for a Healthy Texas, a business plan to guide activities. Included in that plan was an initiative related to supplemental and directed-payment programs with the goal described below:

#### **Goal 1: Increase Oversight and Monitoring of Local Funding Structures**

Improve accountability over the transfer of locally derived government funds by increasing oversight and monitoring of local funding structures.

##### **Strategy**

In FY 2020, more than \$10 billion in Medicaid payments will be made in Texas through supplemental and directed payment programs. To receive federal reimbursements for Medicaid services, public dollars from local governments are used as matching funds. HHS supports implementation and provides oversight of local fund transfers, including those of governmental agencies that operate Local Provider Participation Funds (LPPFs).

The federal government restricts the types of funds that can be used for the matching share of a Medicaid payment and requires HHS to ensure those conditions are met.

To improve oversight of local fund transfers, HHS is developing reporting mechanisms and implementing enhanced monitoring strategies.

HHS will also develop rules and an online reporting portal for governmental entities that operate LPPFs. We will assess how ongoing monitoring should occur for all other sources of the non-federal share of supplemental and directed payment programs.

<b>Deliverables</b> <b>Deliverable</b>	<b>Target Completion</b>
Implement reporting rules for governmental entities that operate LPPFs.	November 2019
Review and validate information reported to HHS by governmental entities that operate LPPFs quarterly.	January 2020 and ongoing
Develop and implement reporting portal for governmental entities that operate LPPFs.	January 2020
Complete data assessment for enhanced reporting and monitoring of additional local funding structures.	April 2020
Develop accountability monitoring plan for additional local funding structures.	August 2020

Attachment B – Oversight and Monitoring Plan for Local Funds Used in Medicaid in Texas

## Fiscal Year 2021 Steps Taken:

### **Release of the Texas Monitoring Plan for Public Comment**

Texas HHSC launched the LPPF reporting system and began collecting quarterly reports in 2020. After a few quarters of collecting quarterly reports, even in the midst of COVID-19, Texas focused efforts on developing the accountability monitoring plan for additional local structures. In addition, based upon lessons learned from the initial LPPF-specific quarterly reports, Texas made plans to refine the reporting required from governmental entities that operate LPPFs and to expand to other types of local fund sources in the future. The plan was posted for public comment in October and November 2020. The plan consists of 5 steps:

1. Annual survey
2. Risk assessment
3. Additional information for selected entities
4. Deep dive reviews
5. Determination

After receiving public comment, it became clear that additional resources for both staff and information technology systems would be necessary to successfully implement the plan as there are as many as 1500 identified different governmental entities that submit or certify local funds for use as non-federal share in the Medicaid program.

### **Investment in Resources Needed to Launch the Monitoring Plan**

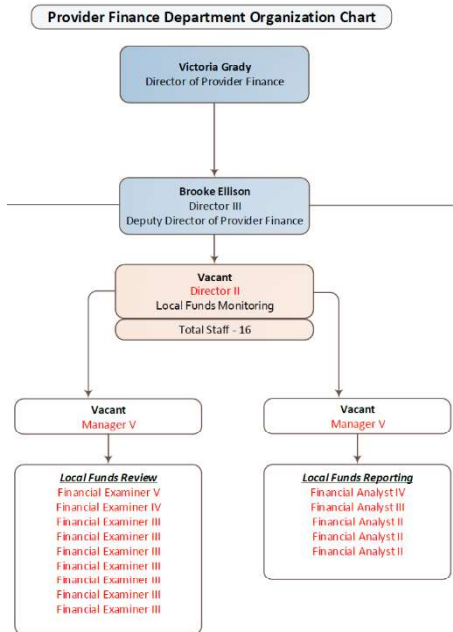
The 87<sup>th</sup> Texas Legislature met in Regular Session from January 12, 2021 through May 31, 2021. During the Regular Session, the Texas Legislature appropriated at least 14 Full Time Equivalents and capital authority for the information technology system necessary to implement the Monitoring Plan. The resources are appropriated to HHSC with an effective date of September 1, 2021.

On June 18, 2021, Senate Bill 1, 87<sup>th</sup> Texas Legislature, Regular Session, 2021, was signed into law. HHSC immediately put steps into motion to implement the creation of the resources. On August 2, 2021, the Director of Local Funds Monitoring position was posted and began accepting applications. The initial set of applications received have been reviewed and first round interviews are schedule for early September.

## Attachment B – Oversight and Monitoring Plan for Local Funds Used in Medicaid in Texas

### Fiscal Year 2022-23 Planned Steps:

#### Complete Staffing for All New Positions



HHSC plans to fill 17 full time equivalent positions to support the Local Funds Monitoring teams. The planned structure includes the Local Funds Review team of Financial Examiners who will be responsible for the implementation of steps 1 through 4 of the Monitoring Plan. The Local Funds Reporting team will be responsible for working HHSC legal counsel to complete step 5 of the monitoring plan. The Reporting team will also complete all federal and state reporting related to the use of local funds in the Medicaid program.

To ensure that the positions are filled timely, HHSC plans to use the dates below as goals (assuming applications are received from a sufficient pool of qualified candidates).

	Director and Managers	Financial Analyst IV and Financial Examiner V	Financial Analyst III and Financial Examiner IV	Financial Analyst II and Financial Examiner III
Positions Posted	8/2/2021	9/10/2021	10/8/2021	11/5/2021
Posting Closes	8/16/2021	9/24/2021	10/22/2021	11/19/2021
Interviews Begin	9/3/2021	10/1/2021	10/29/2021	11/26/2021
Offers Made	9/14/2021	10/12/2021	11/9/2021	12/7/2021
Potential Start Date	9/28/2021	10/26/2021	11/23/2021	12/21/2021

#### Finalize Monitoring Plan via Texas Rulemaking Procedures

While HHSC undertook a public comment process on the draft Monitoring Plan in October and November 2020, implementation of the plan will require the creation of formal Texas regulations via the Texas rulemaking procedures.

The proposed rules targeted date for publication is December 1, 2021. Assuming a public comment period of 30-days, as is typical, HHSC will likely need several weeks to review in January and February to examine all comments and make any necessary modifications in response to public comment.

The Final Rules will likely be published for adoption around March 31, 2022.

Attachment B – Oversight and Monitoring Plan for Local Funds Used in Medicaid in Texas

## Implement Monitoring All Phases

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HHSC will expand monitoring activities based upon provider type, volume of funds, and method of contribution according to the phases and targeted dates below.

Phase	Description	Target Implementation Date
1	Governmental entities operating Local Provider Participation Funds or other provider tax structures	Partially Implemented in 2020; Full Implementation on April 1, 2022
2	Governmental entities transferring non-LPPF funds to support Medicaid payment programs for hospital services	October 1, 2022
3	Governmental entities transferring non-LPPF funds to support Medicaid payment programs for non-hospital services, including nursing facility services, intermediate care facility services, and other acute or long-term care services	April 1, 2023
4	Governmental entities certifying public expenditures	October 1, 2023



Rider 26 Report for Federal Fiscal Year 2021  
Quarter 3 (APR to JUN)  
Mandatory Payments and Administrative Expenditures

Hospital Mandatory Payments by LPPF		Administrative Expenses		
LPPF and Hospitals	Mandatory Payments	Contract Amount for Admin/Operation	Contract Amount for Assess/Collect	Non-contract Admin Expenditure
<b>Amarillo Hospital District</b>				
Baptist St Anthonys Hospital	\$ 2,560,228.00			
Northwest Texas Hospital	\$ 3,528,258.00			
Physicians Surgical Hospital-quail Creek Campus	\$ 550,536.00			
Vibra Hospital Of Amarillo	\$ 124,085.00			
Vibra Rehabilitation Hospital Of Amarillo	\$ 58,739.00			
<b>Amarillo Hospital District Total</b>	<b>\$ 6,821,846.00</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
<b>Angelina County</b>				
Chi St Lukes Health Memorial Lufkin	\$ 1,240,439.00			
Oceans Behavioral Hospital Of Lufkin	\$ 29,511.25			
Post Acute Medical Specialty Hospital Of Lufkin	\$ 22,037.25			
Woodland Heights Medical Center	\$ 1,034,854.00			
<b>Angelina County Total</b>	<b>\$ 2,326,841.50</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
<b>Bell County</b>				
Adventhealth Central Texas	\$ 1,371,721.27			
Baylor Scott & White Continuing Care Hospital	\$ 136,353.52			
Baylor Scott & White Medical Center - Temple	\$ 14,186,204.34			
Cedar Crest Hospital	\$ 169,409.80			
Seton Medical Center Harker Heights	\$ 931,422.13			
<b>Bell County Total</b>	<b>\$ 16,795,111.06</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
<b>Bexar County Hospital District</b>				
Ang Specialty Hospital San Antonio (closing)	\$ -			
Baptist	\$ 19,962,402.79			
Chosa	\$ 4,167,996.46			
Clarity	\$ -			
Cumberland Surgical Hospital	\$ -			
Emerus	\$ 1,563,390.00			
Foundation Surgical Hospital Of San Antonio	\$ 600,945.35			
Healthsouth Rehabilitation Institute Of San Antonio	\$ 335,890.10			
Kindred Hospital - San Antonio	\$ 246,762.62			
Kindred Hospital - San Antonio Central	\$ 298,350.55			
Laurel Ridge Treatment Center	\$ 1,222,218.92			
Lifecare Hospitals Of San Antion (parent Co. In Bankruptcy)	\$ 662,445.51			
Mash	\$ -			
Methodist	\$ 28,519,130.22			
Nix (building For Sale)	\$ -			

Rider 26 Report for Federal Fiscal Year 2021  
Quarter 3 (APR to JUN)  
Mandatory Payments and Administrative Expenditures

Hospital Mandatory Payments by LPPF		Administrative Expenses		
LPPF and Hospitals	Mandatory Payments	Contract Amount for Admin/Operation	Contract Amount for Assess/Collect	Non-contract Admin Expenditure
San Antonio Behavioral Healthcare Hospital	\$ 519,479.14			
Santa Rosa	\$ 7,114,314.29			
South Texas Spine And Surgical Hospital	\$ 948,332.82			
Southwest General	\$ 1,420,511.05			
Stone Oak	\$ 4,618,546.56			
Warm Springs Rehabilitation Hospital Of San Antonio	\$ 1,324,419.82			
Warm Springs Specialty Hospital Of San Antonio	\$ 365,826.29			
<b>Bexar County Hospital District Total</b>	<b>\$ 73,890,962.49</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 4,918.00</b>
<b>Bowie County</b>				
Christus St Michael Health System	\$ -			
Christus St Michael Rehabilitation Hospital	\$ -			
Encompass Health Rehabilitation Hospital Of Texarkana	\$ -			
Pam Specialty Hospital Of Texarkana North	\$ -			
Wadley Regional Medical Center	\$ -			
<b>Bowie County Total</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
<b>Brazos County</b>				
Caprock Hospital	\$ 34,553.49			
Chi St Joseph Health Regional Hospital	\$ -			
CHI St Joseph Rehab Hospital	\$ 131,602.26			
College Station Medical Center	\$ -			
Scott White Hospital College Station	\$ 1,026,835.04			
Strategic Bhcollege Station	\$ -			
The Physicians Centre Hospital	\$ 166,381.07			
<b>Brazos County Total</b>	<b>\$ 1,359,371.86</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
<b>Cameron County</b>				
Harlingen Medical Center	\$ 2,791,328.98			
PALMS BEHAVIORAL HEALTH	\$ 349,803.39			
Solara Hospital Harlingen	\$ 1,163,865.40			
South Texas Rehabilitation Hospital	\$ 153,022.62			
Valley Baptist Medical Center	\$ 8,827,407.03			
Valley Baptist Medical Center - Brownsville	\$ 3,899,304.30			
Valley Regional Medical Center	\$ 4,773,063.31			
<b>Cameron County Total</b>	<b>\$ 21,957,795.03</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
<b>Cherokee County</b>				
CHRISTUS Mother Frances Hospital-Jacksonville	\$ -			

Rider 26 Report for Federal Fiscal Year 2021  
Quarter 3 (APR to JUN)  
Mandatory Payments and Administrative Expenditures

Hospital Mandatory Payments by LPPF		Administrative Expenses		
LPPF and Hospitals	Mandatory Payments	Contract Amount for Admin/Operation	Contract Amount for Assess/Collect	Non-contract Admin Expenditure
Tmfhs	\$ -			
Ut Health	\$ -			
UT Health-Jacksonville	\$ -			
<b>Cherokee County Total</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
<b>City of Beaumont</b>				
Baptist Hospitals Of Southeast Texas	\$ 6,071,219.14			
Christus Dubuis Hospital Of Beaumont	\$ 141,603.44			
Christus Southeast Texas - St Elizabeth In Beaumont	\$ 4,092,130.11			
Kate Dishman Rehabilitation Hospital	\$ -			
Pam Squared At Beaumont, LLC	\$ 140,024.94			
<b>City of Beaumont Total</b>	<b>\$ 10,444,977.63</b>	<b>\$ 20,000.00</b>	<b>\$ -</b>	<b>\$ -</b>
<b>El Paso County Hospital District LPPF</b>				
El Paso Behavioral Health System Uhs	\$ 1,321,002.21			
El Paso Children's Hospital Epch	\$ 2,133,243.93			
El Paso Ltac Hospital El Paso Ltac	\$ 249,715.08			
Foundation Surgical Hospital Of El Paso Foundation Hospitals	\$ -			
Highlands Rehabilitation Hospital Vibra	\$ 190,626.92			
Kindred Hospital El Paso Kindred	\$ 476,052.72			
Las Palmas Medical Center HCA	\$ 14,361,124.83			
Mesa Hill Specialty Hospital Concord	\$ -			
Providence Horizon	\$ 467,851.11			
Providence Transmountain	\$ 2,518,073.46			
Rio Vista Behavioral Health	\$ 128,193.87			
The Hospitals Of Providence East Campus Tenet	\$ 6,151,286.37			
The Hospitals Of Providence Memorial Campus Tenet	\$ 6,510,641.57			
The Hospitals Of Providence Sierra Campus Tenet	\$ 4,076,867.59			
<b>El Paso County Hospital District LPPF Total</b>	<b>\$ 38,584,679.66</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
<b>Ellis County</b>				
Baylor Medical Center At Waxahachie	\$ 2,947,839.00			
Ennis Regional Medical Center	\$ 314,854.00			
<b>Ellis County Total</b>	<b>\$ 3,262,693.00</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

Rider 26 Report for Federal Fiscal Year 2021  
Quarter 3 (APR to JUN)  
Mandatory Payments and Administrative Expenditures

Hospital Mandatory Payments by LPPF		Administrative Expenses		
LPPF and Hospitals	Mandatory Payments	Contract Amount for Admin/Operation	Contract Amount for Assess/Collect	Non-contract Admin Expenditure
<b>Grayson County</b>				
Baylor Scott & White Surgical Hospital At Sherman	\$ 885,374.00			
Carrus Rehabilitation	\$ 173,065.50			
Carrus Specialty Hospital	\$ 245,953.25			
Reba Mcintire Center For Rehabilitation - Part Of Texoma Medical Center	\$ -			
Texoma Medical Center	\$ 5,227,485.75			
Tmc Behavioral Health Center - Part Of Texoma Medical Center	\$ -			
Wilson N Jones Regional Medical Center	\$ 1,019,370.25			
<b>Grayson County Total</b>	<b>\$ 7,551,248.75</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
<b>Gregg County</b>				
Christus Good Shepherd Medical Center - Longview	\$ 8,984,910.50			
Longview Regional Medical Center	\$ 7,024,051.50			
Oceans Behavioral Hospital Longview (prev. Audubon)	\$ 113,877.75			
Select Specialty Hospital-Longview, Inc.	\$ 163,608.00			
<b>Gregg County Total</b>	<b>\$ 16,286,447.75</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
<b>Harris County Hospital District</b>				
Ad Hospital East LLC (Advanced Diagnostics)	\$ -			
Altus Baytown Hospital	\$ -			
Cornerstone Houston Healthcare Specialty Hospital Medical Center	\$ 280,407.09			
Cornerstone Specialty Hospitals Bellaire(Includes Cornerstone Specialty Hospitals Clear Lake)	\$ 535,473.41			
Cornerstone Specialty Hospitals Houston	\$ 282,368.19			
Encompass Health Rehab Hospital - Cypress	\$ 458,856.11			
Encompass Health Rehab Hospital - Humble	\$ 419,163.59			
Encompass Health Rehab Hospital - The Vintage	\$ 437,018.68			
First Texas Hospital	\$ -			
HCA Houston Healthcare Clear Lake	\$ 8,545,353.39			
HCA Houston Healthcare Cypress Fairbanks	\$ -			
HCA Houston Healthcare Medical Center	\$ 1,223,791.19			
HCA Houston Healthcare North Cypress	\$ 10,514,542.46			
HCA Houston Healthcare Northwest	\$ 3,865,988.25			
HCA Houston Healthcare Southeast	\$ 3,940,632.01			
HCA Houston Healthcare Tomball	\$ 2,803,993.96			
HCA Houston Healthcare West	\$ 3,290,606.50			
HCA Texas Orthopedic Hospital	\$ 2,972,661.39			
HCA The Woman's Hospital Of Texas	\$ 6,882,055.69			
Houston Behavioral Healthcare Hospital	\$ 467,230.52			
Houston Methodist Baytown Hospital	\$ 4,584,023.45			

Rider 26 Report for Federal Fiscal Year 2021  
Quarter 3 (APR to JUN)  
Mandatory Payments and Administrative Expenditures

Hospital Mandatory Payments by LPPF		Administrative Expenses	
LPPF and Hospitals	Mandatory Payments	Contract Amount for Admin/Operation	Contract Amount for Assess/Collect
Houston Methodist Clear Lake Hospital	\$ 2,813,437.80		
Houston Methodist Continuing Care Hospital	\$ 442,564.68		
Houston Methodist Hospital	\$ 33,605,207.33		
Houston Methodist West Hospital	\$ 5,398,845.60		
Houston Methodist Willowbrook Hospital	\$ 7,394,898.12		
Houston Physicians' Hospital	\$ 1,224,308.94		
Icon Hospital, LLP	\$ -		
Intracare North Hospital	\$ 288,654.28		
Kindred Hospital Clear Lake	\$ 574,438.48		
Kindred Hospital Houston Medical Center	\$ 1,056,944.68		
Kindred Hospital Houston Northwest(includes Kindred Hospital Bay Area)	\$ 900,385.01		
Kindred Hospital Tomball(includes Kindred Hospital - Spring)	\$ -		
Lone Star Behavioral Health Cypress	\$ 0.27		
Memorial Hermann Hospital System	\$ 27,779,632.27		
Memorial Hermann Katy Hospital	\$ 4,407,982.29		
Memorial Hermann Memorial City Medical Center(includes Women's Memorial Hermann Memorial City)	\$ 8,823,940.72		
Memorial Hermann Northeast Hospital	\$ 4,411,886.34		
Memorial Hermann Rehabilitation Hospital-katy	\$ 480,271.86		
Memorial Hermann Texas Medical Center (includes Memorial Hermann Orthopedic & Spine Hospital,	\$ 29,606,629.89		
Children's Memorial Hermann Hospital, And Memorial Hermann Cypress Hospital)	\$ -		
Memorial Hermann Tomball	\$ -		
Nexus Children's Hospital - Houston Campus	\$ 200,785.87		
Oceans Behavioral Hospital Of Katy	\$ 31,543.09		
Oceans Behavioral Hospital of Pasadena	\$ 167,232.24		
PAM Kindred Rehabilitation Hospital Clear Lake	\$ 171,737.88		
PAM Kindred Rehabilitation Hospital Northeast Houston	\$ 336,835.08		
Pam Rehabilitation Hospital Of Clear Lake	\$ -		
Providence Hospital Of North Houston LLC	\$ -		
Sacred Oak Medical Center	\$ 4,247,537.73		
Saint Joseph Medical Center (includes The Heights)	\$ -		
Shriners Hospitals For Children	\$ 16,120,754.55		
St. Luke's Health Baylor College Of Medicine	\$ 1,370,877.45		
St. Luke's Hospital At The Vintage	\$ 1,482,856.66		
St. Luke's Patients Medical Center	\$ 491,030.04		
Sun Behavioral Houston	\$ 375,301.89		
Surgery Specialty Hospitals Of America Se Houston	\$ 37,650,868.94		
Texas Children's Hospital (includes West Campus)	\$ 2,258,952.66		
Tirr Memorial Hermann	\$ 796,732.46		
Tops Surgical Specialty Hospital	\$ -		

Rider 26 Report for Federal Fiscal Year 2021  
Quarter 3 (APR to JUN)  
Mandatory Payments and Administrative Expenditures

Hospital Mandatory Payments by LPPF		Administrative Expenses		
LPPF and Hospitals	Mandatory Payments	Contract Amount for Admin/Operation	Contract Amount for Assess/Collect	Non-contract Admin Expenditure
Townsen Memorial Hospital	\$ -			
Ugh Pain And Spine	\$ -			
UHS West Oaks Hospital	\$ 665,925.90			
UHS Behavioral Hospital Of Bellaire	\$ 426,761.97			
UHS Cypress Creek Hospital	\$ 499,149.86			
UHS Kingwood Pines Hospital	\$ 380,418.43			
United Memorial Medical Center (UMMC)	\$ -			
<b>Harris County Hospital District Total</b>	<b>\$ 248,389,497.14</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 150,000.00</b>
<b>Hays County</b>				
Central Texas Medical Center	\$ -			
CHRISTUS Santa Rosa Hospital San Marcos	\$ -			
Seton Medical Center Hays	\$ 3,975,549.48			
Warm Springs Rehabilitation Hospital Of Kyle	\$ 254,216.36			
Wellbridge Hospital Of San Marcos	\$ -			
<b>Hays County Total</b>	<b>\$ 4,229,765.84</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
<b>Hidalgo County</b>				
Cornerstone Regional Hospital	\$ 229,503.24			
Doctors Hospital At Renaissance	\$ 9,254,257.95			
Knapp Medical Center	\$ 1,426,439.30			
McAllen Medical Center	\$ 19,363,640.44			
Mission Regional Medical Center	\$ 1,831,253.16			
Rio Grande Regional Hospital	\$ 4,153,197.02			
Solara Hospital Mcallen	\$ -			
Weslaco Regional Rehabilitation Hospital	\$ 170,425.17			
<b>Hidalgo County Total</b>	<b>\$ 36,428,716.28</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
<b>JPS Health Network (Tarrant County Hospital District)</b>				
Baylor Orthopedic And Spine Hospital At Arlington	\$ 734,878.49			
Baylor Scott & White All Saints Medical Center - Fort Worth	\$ 4,876,936.83			
Baylor Scott & White Emergency Hospital Burleson	\$ 170,183.87			
Baylor Scott & White Institute For Rehabilitation - Fort Worth	\$ 157,869.37			
Baylor Scott & White Medical Center - Grapevine	\$ 3,484,858.86			
Baylor Surgical Hospital At Fort Worth	\$ 710,487.29			
Cook Childrens Medical Center	\$ 12,948,258.20			
Encompass Health Rehabilitation Hospital Of Arlington	\$ 404,677.99			
Encompass Health Rehabilitation Hospital Of City View	\$ 315,599.95			
Encompass Health Rehabilitation Hospital Of The Mid-cities	\$ 287,159.74			

Rider 26 Report for Federal Fiscal Year 2021  
Quarter 3 (APR to JUN)  
Mandatory Payments and Administrative Expenditures

Hospital Mandatory Payments by LPPF		Administrative Expenses		
LPPF and Hospitals	Mandatory Payments	Contract Amount for Admin/Operation	Contract Amount for Assess/Collect	Non-contract Admin Expenditure
Ethicus Hospital DFW LLC	\$ -			
Kindred Hospital - Fort Worth	\$ -			
Kindred Hospital-mansfield	\$ 91,813.58			
Kindred Hospital-tarrant County	\$ 253,234.55			
Kindred Hospital Tarrant County Arlington	\$ 109,085.97			
Lifecare Hospitals Of Fort Worth	\$ -			
Medical City Alliance	\$ 1,296,648.98			
Medical City Arlington	\$ 4,026,605.90			
Medical City Fort Worth	\$ 3,617,165.64			
Medical City North Hills	\$ 1,706,827.66			
Mesa Springs	\$ 324,395.22			
Methodist Mansfield Medical Center	\$ 3,212,703.84			
Methodist Southlake Hospital	\$ 701,119.47			
Millwood Hospital	\$ 215,306.96			
Saint Camillus Medical Center	\$ -			
Sundance Hospital	\$ -			
Texas Health Arlington Memorial Hospital	\$ 3,603,353.04			
Texas Health Harris Methodist Hospital Alliance	\$ 1,773,290.07			
Texas Health Harris Methodist Hospital Azle	\$ 441,600.50			
Texas Health Harris Methodist Hospital Fort Worth	\$ 11,269,366.51			
Texas Health Harris Methodist Hospital Hurst-euless-bedford	\$ 3,199,797.78			
Texas Health Harris Methodist Hospital Southlake	\$ 959,547.39			
Texas Health Harris Methodist Hospital Southwest Fort Worth	\$ 4,157,733.28			
Texas Health Heart & Vascular Hospital Arlington	\$ 726,660.54			
Texas Health Huguley Hospital	\$ 2,699,972.15			
Texas Health Specialty Hospital Fort Worth	\$ 118,737.29			
Texas Rehabilitation Hospital Of Arlington	\$ 238,461.68			
Texas Rehabilitation Hospital Of Fort Worth	\$ 169,860.53			
Usmd Hospital At Arlington	\$ 1,149,892.95			
Usmd Hospital At Fort Worth	\$ -			
Wellbridge Hospital Of Fort Worth	\$ 89,984.58			
<b>JPS Health Network (Tarrant County Hospital District) Total</b>	<b>\$ 70,244,076.65</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
<b>Lubbock County Hospital District</b>				
Covenant Children's Hospital	\$ 4,778,932.00			
Covenant Medical Center	\$ 6,378,391.00			
Covenant Specialty Hospital	\$ -			
Grace Medical Center	\$ 820,414.00			
Lubbock Heart And Surgical Center	\$ -			



Rider 26 Report for Federal Fiscal Year 2021  
Quarter 3 (APR to JUN)  
Mandatory Payments and Administrative Expenditures

Hospital Mandatory Payments by LPPF		Administrative Expenses		
LPPF and Hospitals	Mandatory Payments	Contract Amount for Admin/Operation	Contract Amount for Assess/Collect	Non-contract Admin Expenditure
South Plains Rehabilitation Hospital	\$ -			
Trustpoint Rehabilitation Hospital	\$ -			
<b>Lubbock County Hospital District Total</b>	<b>\$ 11,977,737.00</b>			
<b>McLennan County</b>				
Baylor Scott & White Medical Center - Hillcrest	\$ 4,952,932.26			
Providence Health Services Of Waco - Providence Healthcare Network	\$ 7,886,277.16			
<b>McLennan County Total</b>	<b>\$ 12,839,209.42</b>	<b>\$ 20,000.00</b>	<b>\$ -</b>	<b>\$ -</b>
<b>Nueces County Hospital District</b>				
Christus Spohn Hospital Corpus Christi	\$ -			
Corpus Christi Rehabilitation Hospital	\$ -			
Driscoll Children's Hospital	\$ 9,352,363.00			
PAM Rehabilitation Hospital of Corpus Christi	\$ -			
PAM Specialty Hospital of Corpus Christi North	\$ -			
South Texas Surgical Hospital	\$ -			
The Corpus Christi Medical Center - Bay Area	\$ -			
<b>Nueces County Hospital District Total</b>	<b>\$ 9,352,363.00</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
<b>Parkland Hospital System (Dallas County Hospital District)</b>				
Baylor Medical Center At Uptown	\$ 722,703.16			
Baylor Scott & White Heart And Vascular Hospital - Dallas	\$ 3,631,410.16			
Baylor Scott & White Institute For Rehabilitation	\$ 444,721.76			
Baylor Scott & White Medical Center - Irving	\$ 3,740,247.72			
Baylor Scott & White Medical Center - Sunnyvale	\$ 2,363,668.16			
Baylor Surgical Hospital At Las Colinas	\$ 659,733.27			
Baylor University Medical Center	\$ 20,700,779.42			
Childrens Medical Center Of Dallas	\$ 21,814,988.54			
City Hospital At White Rock	\$ 2,667,465.22			
Crescent Medical Center Lancaster	\$ 371,835.32			
Dallas Behavioral Healthcare Hospital LLC	\$ 422,208.92			
Dallas Medical Center	\$ 1,184,675.82			
Dallas Regional Medical Center	\$ 1,703,465.90			
Encompass Health Rehabilitation Hospital Of Dallas	\$ 166,928.89			
Encompass Health Rehabilitation Hospital Of Richardson	\$ 228,965.06			
First Baptist Medical Center	\$ 376,225.04			
Garland Behavioral Hospital	\$ 233,259.18			
Green Oaks Hospital	\$ 829,837.22			
Hickory Trail Hospital	\$ 329,513.74			

Rider 26 Report for Federal Fiscal Year 2021  
Quarter 3 (APR to JUN)  
Mandatory Payments and Administrative Expenditures

Hospital Mandatory Payments by LPPF		Administrative Expenses		
LPPF and Hospitals	Mandatory Payments	Contract Amount for Admin/Operation	Contract Amount for Assess/Collect	Non-contract Admin Expenditure
Kindred Hospital - Dallas	\$ -			
Kindred Hospital Dallas Central	\$ 217,018.57			
KPC Promise Hospital	\$ 48,854.03			
Lifecare Hospitals Of Dallas	\$ 186,707.81			
Medical City Dallas Hospital	\$ 18,769,053.80			
Medical City Las Colinas	\$ 1,958,583.96			
Mesquite Rehabilitation Institute	\$ -			
Mesquite Specialty Hospital	\$ -			
Methodist Dallas Medical Center	\$ 7,524,150.16			
Methodist Charlton Medical Center	\$ 4,442,659.50			
Methodist Hospital For Surgery	\$ 1,667,749.62			
Methodist Rehabilitation Hospital	\$ 417,127.82			
North Central Surgical Center LLP	\$ 2,158,503.82			
Our Childrens House	\$ 589,869.45			
Pine Creek Medical Center	\$ -			
Select Specialty Hospital - Dallas	\$ -			
Select Specialty Hospital - Dallas (downtown)	\$ 156,726.64			
Texas Health Hospital / Legent Orthopedic Hospital	\$ -			
Texas Health Presbyterian Hospital Dallas	\$ 12,132,628.76			
Texas Institute For Surgery At Texas Health Presbyterian Dallas	\$ 745,245.07			
Texas Scottish Rite Hospital For Children	\$ 600,318.67			
Vibra Specialty Hospital	\$ 254,652.02			
<b>Parkland Hospital System (Dallas County Hospital District) Total</b>	<b>\$ 114,462,482.20</b>	<b>\$ 150,000.00</b>	<b>\$ -</b>	<b>\$ -</b>
<b>Smith County</b>				
Christus Mother Frances Hospital - Tyler	\$ 7,923,793.39			
Christus Trinity Mother Frances Rehab Hospital (a Partner Of Encompass)	\$ -			
Texas Spine And Joint Hospital	\$ -			
Tyler Continue Care Hospital At Mother Frances Hospital	\$ -			
Ut Health East Texas Rehabilitation Hospital	\$ -			
Ut Health East Texas Specialty Hospital	\$ -			
Ut Health Tyler	\$ 4,708,664.66			
<b>Smith County Total</b>	<b>\$ 12,632,458.05</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
<b>Taylor County</b>				
Abilene Regional Medical Center	\$ 1,184,014.75			
ContinueCare at Hendrick Medical Center	\$ 91,436.80			
Encompass Health Rehabilitation Hospital of Abilene	\$ 216,476.87			
Hendrick Medical Center	\$ 3,927,682.24			

Rider 26 Report for Federal Fiscal Year 2021  
Quarter 3 (APR to JUN)  
Mandatory Payments and Administrative Expenditures

Hospital Mandatory Payments by LPPF		Administrative Expenses		
LPPF and Hospitals	Mandatory Payments	Contract Amount for Admin/Operation	Contract Amount for Assess/Collect	Non-contract Admin Expenditure
Oceans Behavioral Hospital of Abilene	\$ 360,298.68			
<b>Taylor County Total</b>	<b>\$ 5,779,909.34</b>	\$ -	\$ -	\$ -
<b>Tom Green County</b>				
River Crest Hospital	\$ 80,719.80			
San Angelo Community Medical Center	\$ -			
Shannon West Texas Memorial Hospital	\$ 4,784,564.16			
<b>Tom Green County Total</b>	<b>\$ 4,865,283.96</b>	\$ -	\$ -	\$ -
<b>Travis County (Central Health Hospital District)</b>				
Arise Austin Medical Center	\$ -			
Ascension Seton Medical Center Austin	\$ 7,724,303.00			
Ascension Seton Northwest	\$ 1,511,146.00			
Ascension Seton Shoal Creek	\$ 276,314.00			
Ascension Seton Southwest	\$ 460,417.00			
Austin Lakes Hospital	\$ 309,519.00			
Austin Oaks Hospital	\$ 313,019.00			
Baylor Scott & White Institute For Rehabilitation - Lakeway	\$ 529,352.00			
Baylor Scott & White Medical Center - Pflugerville	\$ 309,563.00			
Central Texas Rehabilitation Hospital	\$ 344,873.00			
Cornerstone Specialty Hospitals Austin (includes Cornerston Specialty Hospitals Round Rock)	\$ 639,559.00			
Cross Creek Hospital	\$ 276,328.00			
Dell Childrens Medical Center	\$ 8,886,593.00			
Dell Seton Medical Center At The University Of Texas	\$ 6,316,205.00			
Encompass Health Rehabilitation Hospital Of Austin	\$ 427,182.00			
Lake Travis ER LLC	\$ 8,936.00			
North Austin Medical Center (includes St. Davids's Surgical Hospital)	\$ 9,542,292.00			
Northwest Hills Surgical Hospital	\$ 578,698.00			
St Davids Medical Center (includes St David's Rehab, Heart Hospital Of Austin, St. David's Georgetown)	\$ 14,874,323.00			
St Davids South Austin Medical Center	\$ 8,003,616.00			
Texas Neurorehab Center	\$ 710,929.00			
Texas Star Recovery	\$ -			
The Hospital At Westlake Medical Center	\$ -			
<b>Travis County (Central Health Hospital District) Total</b>	<b>\$ 62,043,167.00</b>	\$ -	\$ -	\$ 150,000.00
<b>Webb County</b>				
Doctors Hospital Of Laredo	\$ -			
Laredo Medical Center	\$ -			
Laredo Rehabilitation Hospital	\$ -			

Rider 26 Report for Federal Fiscal Year 2021  
Quarter 3 (APR to JUN)  
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Hospital Mandatory Payments by LPPF		Administrative Expenses		
LPPF and Hospitals	Mandatory Payments	Contract Amount for Admin/Operation	Contract Amount for Assess/Collect	Non-contract Admin Expenditure
Laredo Specialty Hospital	\$ -			
Providence Hospital	\$ -			
<b>Webb County Total</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 22,126.15</b>
<b>Wichita County</b>				
Encompass Health Rehabilitation Hospital Of Wichita Falls	\$ 795,729.30			
Kell West Regional Hospital	\$ 838,744.56			
Promise Hospital Of Wichita Falls Inc	\$ 58,842.63			
Red River Hospital	\$ 468,560.44			
United Regional Health Care System	\$ 9,073,140.08			
<b>Wichita County Total</b>	<b>\$ 11,235,017.01</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
<b>Williamson County</b>				
Baylor Scott & White Emergency Medical Center - Cedar Park	\$ 9,346.25			
Baylor Scott & White Medical Center - Round Rock	\$ 1,348,956.00			
Baylor Scott & White Medical Center - Taylor	\$ 87,750.50			
Cedar Park Regional Medical Center	\$ 455,273.25			
Encompass Health Rehabilitation Hospital Of Round Rock	\$ 95,252.00			
Georgetown Behavioral Health Institute	\$ 53,093.00			
PAM Rehabilitation Hospital of Round Rock	\$ 54,029.50			
Rock Springs	\$ 60,852.25			
Round Rock Medical Center	\$ 850,514.50			
Seton Medical Center Williamson	\$ 2,165,282.00			
<b>Williamson County Total</b>	<b>\$ 5,180,349.25</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

LPPF Intergovernmental Transfers by Medicaid Program					
LPPF	DSRIP	CHIRP (Replaced UHRIP)	TIPPS	RAPPS	UC
Amarillo Hospital District LPPF		\$8,560,579.00			\$270,734.66
Angelina County LPPF		\$5,680,645.88			\$187,014.66
Bell County LPPF		\$19,974,939.02	\$1,990,988.74	\$25,967.28	\$477,014.14
Bowie County LPPF		\$6,770,873.41			
Brazos County Texas LPPF		\$5,964,902.71			\$245,128.03
CAMERON COUNTY HEALTHCARE FUNDING LPPF		\$18,893,295.38			\$795,940.35
City of Beaumont LPPF		\$11,432,214.95			\$288,931.08
COUNTY OF ELLIS LPPF		\$3,031,999.69			\$335,257.12
Dallas County Hospital District LPPF		\$129,711,618.94	\$5,995,138.19		\$12,271,875.12
El Paso County Hospital District LPPF		\$32,976,135.83			\$1,185,540.65
Grayson County LPPF		\$4,742,822.43			\$144,740.48
Gregg County LPPF		\$13,267,930.69			\$605,870.86
Harris County Hospital District LPPF		\$274,000,000.00			\$20,366,814.81
Hays County LPPF		\$2,731,019.25			\$233,603.59
Hidalgo County LPPF					\$958,080.41
Lubbock County Hospital District - LPPF		\$11,823,922.76		\$29,317.88	\$1,284,264.72
McLennan County LPPF		\$7,540,163.51		\$211,906.47	\$186,793.59
Nueces County Hospital District LPPF		\$34,982,334.46	\$355,797.54		\$151,685.75
Smith County LPPF		\$11,485,616.35	\$11,174,618.71	\$362,909.93	\$536,259.92
Tarrant County Hospital District LPPF		\$99,087,126.77			\$15,540,154.41
Taylor County LPPF		\$6,367,176.00			\$175,238.65
Tom Green County LPPF		\$5,646,326.00			\$335,750.68
Travis County Healthcare District LPPF		\$53,754,498.18			\$3,550,196.45
University Health System LPPF		\$76,571,370.11	\$22,654.18		\$60,614.80
Webb County LPPF		\$7,176,919.89			\$354,958.27
Wichita County Texas LPPF		\$7,221,424.00			\$187,236.16
Williamson County LPPF		\$5,776,506.77			\$178,492.33

**From:** [HHSC TX Medicaid Waivers](#)  
**To:** [Blunt, Ford J. \(CMS/CMCS\)](#)  
**Cc:** [Montalbano, Kathi \(HHSC\)](#); [Caruthers, Courtney \(HHSC\)](#); [Roland, Dawn \(HHSC\)](#); [Kristian, Diona \(CMS/CMCS\)](#); [Greenfield, Eli S. \(CMS/CMCS\)](#)  
**Subject:** RE: CMS and Texas 1115 Monthly Monitoring Call Agenda - for August 26, 2021  
**Date:** Wednesday, August 25, 2021 3:41:10 PM  
**Attachments:** [image001.png](#)

---

Thank you, Ford for the Zoom information. We are letting our internal folks know.

Sincerely,

*Dawn M. Roland*

Dawn M. Roland, B.S.ED., CMP, CWM  
1915(c), 1915(b), 1915(i) Waivers Program Specialist II  
Policy Development Support  
Medicaid/CHIP Services  
**Texas Health and Human Services Commission**  
[Dawn.Roland@hhs.texas.gov](mailto:Dawn.Roland@hhs.texas.gov)



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**From:** HHSC TX Medicaid Waivers  
**Sent:** Wednesday, August 25, 2021 12:00 PM  
**To:** Blunt, Ford J. (CMS/CMCS) <Ford.Blunt@cms.hhs.gov>  
**Cc:** Montalbano, Kathi (HHSC) <Kathi.Montalbano@hhs.texas.gov>; Caruthers, Courtney (HHSC) <Courtney.Caruthers@hhs.texas.gov>; Dawn M. Roland - HHS/HHSC (Dawn.Roland@hhs.texas.gov) <Dawn.Roland@hhs.texas.gov>  
**Subject:** CMS and Texas 1115 Monthly Monitoring Call Agenda - for August 26, 2021

Good afternoon, Ford,

Please find the agenda items below for both CMS and Texas 1115 Monthly Monitoring Call tomorrow, August 26, 2021 at 2:30 p.m. (EDT). We noticed that the meeting lists WebEx as the platform, but thought this was moving to Zoom. Can you update the invitation with the Zoom information so we can also let our internal folks know?

Thank you.

Sincerely,

*Dawn M. Roland*

Dawn M. Roland, B.S.ED., CMP, CWM  
1915(c), 1915(b), 1915(i) Waivers Program Specialist II  
Policy Development Support  
Medicaid/CHIP Services  
**Texas Health and Human Services Commission**  
[Dawn.Roland@hhs.texas.gov](mailto:Dawn.Roland@hhs.texas.gov)



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\*\*\*\*\*

**CMS and Texas  
1115 Monthly Monitoring Call  
Agenda  
August 26, 2021**

**Date:** August 26, 2021    **Time:** 1:30 p.m.-2:30 p.m. (CDT)  
2:30 p.m.-3:30 p.m. (EDT)

WebEx: 1-877-267-1577; WebEx Meeting Number: 999 515 848;

\*\*\*\*\*

**Agenda Topic 1:**

CMS would like to address technical corrections to the STCs to restart the conversation.

**Agenda Topic 2:**

Texas would like to request updates on the following STC 39(e) deliverables for the PHP-CCP:

DY 11 Attachment T (submitted on March 8, 2021)

DY 11 PHP CCP Tool (submitted on June 30, 2021)

DY 12 Attachment T (submitted on June 30, 2021)

**Agenda Topic 3:**

Texas would also like to notify CMS that Texas has adopted an administrative rule to govern the program for DY11. [https://texreg.sos.state.tx.us/public/readtac\\$ext.TacPage?sl=R&app=9&p\\_dir=&p\\_rloc=&p\\_tloc=&p\\_ploc=&pg=1&p\\_tac=&ti=1&pt=15&ch=355&rl=8215](https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=1&pt=15&ch=355&rl=8215)

The provisions of this §355.8215 were adopted to be effective July 1, 2021, 46 TexReg 3869.

**Agenda Topic 4:**

Texas has also adopted an administrative rule to govern the program for DY12 and after.

[https://texreg.sos.state.tx.us/public/readtac\\$ext.TacPage?sl=T&app=9&p\\_dir=N&p\\_rloc=196954&p\\_tloc=&p\\_ploc=1&pg=3&p\\_tac=&ti=1&pt=15&ch=355&rl=8215](https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=T&app=9&p_dir=N&p_rloc=196954&p_tloc=&p_ploc=1&pg=3&p_tac=&ti=1&pt=15&ch=355&rl=8215)

The provisions of this §355.8217 were adopted to be effective August 24, 2021, 46 TexReg 5175.



**From:** [Young, Gary \(HHSC\)](#)  
**To:** [Smith, Raven \(CMS/CMCS\)](#); [Garner, Angela D. \(CMS/CMCS\)](#); [Cash, Judith \(CMS/CMCS\)](#); [Stephens, Stephanie \(HHSC\)](#)  
**Cc:** [Tsai, Daniel \(CMS/OA\)](#); [Marunycz, Lisa \(CMS/CMCS\)](#); [Kristian, Diona \(CMS/CMCS\)](#); [Greenfield, Eli S. \(CMS/CMCS\)](#); [O'Malley, Kathleen \(CMS/CMCS\)](#)  
**Subject:** Re: DSRIP questions  
**Date:** Wednesday, August 25, 2021 11:24:13 AM

---

Thank you

---

**From:** Smith, Raven (CMS/CMCS) <[Raven.Smith@cms.hhs.gov](mailto:Raven.Smith@cms.hhs.gov)>  
**Sent:** Wednesday, August 25, 2021 10:02 AM  
**To:** Garner, Angela D. (CMS/CMCS) <[Angela.Garner@cms.hhs.gov](mailto:Angela.Garner@cms.hhs.gov)>; Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>; Cash, Judith (CMS/CMCS) <[Judith.Cash@cms.hhs.gov](mailto:Judith.Cash@cms.hhs.gov)>; Stephens, Stephanie (HHSC) <[Stephanie.Stephens01@hhs.texas.gov](mailto:Stephanie.Stephens01@hhs.texas.gov)>  
**Cc:** Tsai, Daniel (CMS/OA) <[Daniel.Tsai@cms.hhs.gov](mailto:Daniel.Tsai@cms.hhs.gov)>; Marunycz, Lisa (CMS/CMCS) <[Lisa.Marunycz@cms.hhs.gov](mailto:Lisa.Marunycz@cms.hhs.gov)>; Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>; Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>; O'Malley, Kathleen (CMS/CMCS) <[Kathleen.OMalley@cms.hhs.gov](mailto:Kathleen.OMalley@cms.hhs.gov)>  
**Subject:** RE: DSRIP questions  
Good morning,  
The call for Friday with Judith has been scheduled for 9:30am EST.  
Thank you,  
Raven Smith

---

**From:** Garner, Angela D. (CMS/CMCS)  
**Sent:** Wednesday, August 25, 2021 5:54 AM  
**To:** Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>; Cash, Judith (CMS/CMCS) <[Judith.Cash@cms.hhs.gov](mailto:Judith.Cash@cms.hhs.gov)>; Stephens, Stephanie (HHSC) <[Stephanie.Stephens01@hhs.texas.gov](mailto:Stephanie.Stephens01@hhs.texas.gov)>  
**Cc:** Tsai, Daniel (CMS/OA) <[Daniel.Tsai@cms.hhs.gov](mailto:Daniel.Tsai@cms.hhs.gov)>; Marunycz, Lisa (CMS/CMCS) <[Lisa.Marunycz@cms.hhs.gov](mailto:Lisa.Marunycz@cms.hhs.gov)>; Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>; Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>; O'Malley, Kathleen (CMS/CMCS) <[Kathleen.OMalley@cms.hhs.gov](mailto:Kathleen.OMalley@cms.hhs.gov)>; Smith, Raven (CMS/CMCS) <[Raven.Smith@cms.hhs.gov](mailto:Raven.Smith@cms.hhs.gov)>  
**Subject:** RE: DSRIP questions  
Good morning,  
I will send the appointment for this morning momentarily to go over the responses to your questions.  
Thanks,  
Angela

---

**From:** Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>  
**Sent:** Tuesday, August 24, 2021 8:39 PM  
**To:** Cash, Judith (CMS/CMCS) <[Judith.Cash@cms.hhs.gov](mailto:Judith.Cash@cms.hhs.gov)>; Garner, Angela D. (CMS/CMCS) <[Angela.Garner@cms.hhs.gov](mailto:Angela.Garner@cms.hhs.gov)>; Stephens, Stephanie (HHSC) <[Stephanie.Stephens01@hhs.texas.gov](mailto:Stephanie.Stephens01@hhs.texas.gov)>  
**Cc:** Tsai, Daniel (CMS/OA) <[Daniel.Tsai@cms.hhs.gov](mailto:Daniel.Tsai@cms.hhs.gov)>; Marunycz, Lisa (CMS/CMCS) <[Lisa.Marunycz@cms.hhs.gov](mailto:Lisa.Marunycz@cms.hhs.gov)>; Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>; Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>; O'Malley, Kathleen (CMS/CMCS) <[Kathleen.OMalley@cms.hhs.gov](mailto:Kathleen.OMalley@cms.hhs.gov)>; Smith, Raven (CMS/CMCS) <[Raven.Smith@cms.hhs.gov](mailto:Raven.Smith@cms.hhs.gov)>

**Subject:** Re: DSRIP questions

Hi Judith - Thanks. We look forward to tomorrow morning's call. Let us know when you have some availability Friday to talk about DSRIP and health equity requirements.

Thanks.

Gary

---

**From:** Cash, Judith (CMS/CMCS) <[Judith.Cash@cms.hhs.gov](mailto:Judith.Cash@cms.hhs.gov)>

**Sent:** Tuesday, August 24, 2021 7:00 PM

**To:** Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>; Garner, Angela D. (CMS/CMCS)

<[Angela.Garner@cms.hhs.gov](mailto:Angela.Garner@cms.hhs.gov)>; Stephens, Stephanie (HHSC)

<[Stephanie.Stephens01@hhs.texas.gov](mailto:Stephanie.Stephens01@hhs.texas.gov)>

**Cc:** Tsai, Daniel (CMS/OA) <[Daniel.Tsai@cms.hhs.gov](mailto:Daniel.Tsai@cms.hhs.gov)>; Marunycz, Lisa (CMS/CMCS)

<[Lisa.Marunycz@cms.hhs.gov](mailto:Lisa.Marunycz@cms.hhs.gov)>; Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>;

Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>; O'Malley, Kathleen (CMS/CMCS)

<[Kathleen.OMalley@cms.hhs.gov](mailto:Kathleen.OMalley@cms.hhs.gov)>; Smith, Raven (CMS/CMCS) <[Raven.Smith@cms.hhs.gov](mailto:Raven.Smith@cms.hhs.gov)>

**Subject:** RE: DSRIP questions

Hi, Gary.

Angela's team can talk through the amendment issues. But we'll need others (including me) for the conversation about the health equity metrics. I am out tomorrow and Thursday. Can we try to find time for that on Friday or Monday? I appreciate your flexibility.

Judith

---

**From:** Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>

**Sent:** Tuesday, August 24, 2021 6:42 PM

**To:** Garner, Angela D. (CMS/CMCS) <[Angela.Garner@cms.hhs.gov](mailto:Angela.Garner@cms.hhs.gov)>; Cash, Judith (CMS/CMCS)

<[Judith.Cash@cms.hhs.gov](mailto:Judith.Cash@cms.hhs.gov)>; Stephens, Stephanie (HHSC) <[Stephanie.Stephens01@hhs.texas.gov](mailto:Stephanie.Stephens01@hhs.texas.gov)>

**Cc:** Tsai, Daniel (CMS/OA) <[Daniel.Tsai@cms.hhs.gov](mailto:Daniel.Tsai@cms.hhs.gov)>; Marunycz, Lisa (CMS/CMCS)

<[Lisa.Marunycz@cms.hhs.gov](mailto:Lisa.Marunycz@cms.hhs.gov)>; Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>;

Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>; O'Malley, Kathleen (CMS/CMCS)

<[Kathleen.OMalley@cms.hhs.gov](mailto:Kathleen.OMalley@cms.hhs.gov)>

**Subject:** Re: DSRIP questions

Hi Angela - We'd like to take the 10 am Eastern (9 am local) time slot. We'd like to go over the questions we submitted yesterday, but also get some specific details from CMS staff regarding the Health Equity requirements.

Thanks,

Gary

---

**From:** Garner, Angela D. (CMS/CMCS) <[Angela.Garner@cms.hhs.gov](mailto:Angela.Garner@cms.hhs.gov)>

**Sent:** Tuesday, August 24, 2021 3:34 PM

**To:** Cash, Judith (CMS/CMCS) <[Judith.Cash@cms.hhs.gov](mailto:Judith.Cash@cms.hhs.gov)>; Stephens, Stephanie (HHSC)

<[Stephanie.Stephens01@hhs.texas.gov](mailto:Stephanie.Stephens01@hhs.texas.gov)>

**Cc:** Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>; Tsai, Daniel (CMS/OA)

<[Daniel.Tsai@cms.hhs.gov](mailto:Daniel.Tsai@cms.hhs.gov)>; Marunycz, Lisa (CMS/CMCS) <[Lisa.Marunycz@cms.hhs.gov](mailto:Lisa.Marunycz@cms.hhs.gov)>; Kristian,

Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>; Greenfield, Eli S. (CMS/CMCS)

<[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>; O'Malley, Kathleen (CMS/CMCS) <[Kathleen.OMalley@cms.hhs.gov](mailto:Kathleen.OMalley@cms.hhs.gov)>

**Subject:** RE: DSRIP questions

Hey Gary,

Does 10 – 11 AM EST tomorrow work for your team?

We also have availability at 3 or 4 PM EST.

Please let us know.

Thanks,

Angela

---

**From:** Cash, Judith (CMS/CMCS)

**Sent:** Tuesday, August 24, 2021 4:26 PM

**To:** Stephens,Stephanie (HHSC) <[Stephanie.Stephens01@hhs.texas.gov](mailto:Stephanie.Stephens01@hhs.texas.gov)>

**Cc:** Young,Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>; Tsai, Daniel (CMS/OA) <[Daniel.Tsai@cms.hhs.gov](mailto:Daniel.Tsai@cms.hhs.gov)>; Garner, Angela D. (CMS/CMCS) <[Angela.Garner@cms.hhs.gov](mailto:Angela.Garner@cms.hhs.gov)>; Marunycz, Lisa (CMS/CMCS) <[Lisa.Marunycz@cms.hhs.gov](mailto:Lisa.Marunycz@cms.hhs.gov)>; Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>

**Subject:** RE: DSRIP questions

Sure.

Unfortunately, I have to be out tomorrow and Thursday. But Angela and her team will make themselves available if you would like to meet before Friday. I'm looping in Angela and Diona to schedule.

Judith

---

**From:** Stephens,Stephanie (HHSC) <[Stephanie.Stephens01@hhs.texas.gov](mailto:Stephanie.Stephens01@hhs.texas.gov)>

**Sent:** Tuesday, August 24, 2021 3:38 PM

**To:** Cash, Judith (CMS/CMCS) <[Judith.Cash@cms.hhs.gov](mailto:Judith.Cash@cms.hhs.gov)>

**Cc:** Young,Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>; Tsai, Daniel (CMS/OA) <[Daniel.Tsai@cms.hhs.gov](mailto:Daniel.Tsai@cms.hhs.gov)>

**Subject:** RE: DSRIP questions

Hi Judith – I chatted with Dan yesterday about setting up a meeting to explore the DSRIP extension option and talk through the questions we sent you. Can Gary work with someone to get this scheduled as soon as possible? Thanks, Stephanie

---

**From:** Cash, Judith (CMS/CMCS) <[Judith.Cash@cms.hhs.gov](mailto:Judith.Cash@cms.hhs.gov)>

**Sent:** Monday, August 23, 2021 1:58 PM

**To:** Young,Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>; Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Montalbano,Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers,Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; Bilse,Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>; Stephens,Stephanie (HHSC) <[Stephanie.Stephens01@hhs.texas.gov](mailto:Stephanie.Stephens01@hhs.texas.gov)>; Deboy, Alissa M. (CMS/CMCS) <[alissa.deboy1@cms.hhs.gov](mailto:alissa.deboy1@cms.hhs.gov)>; Smith, Carrie A. (CMS/CMCS) <[Carrie.Smith@cms.hhs.gov](mailto:Carrie.Smith@cms.hhs.gov)>; Howe, Rory (CMS/CMCS) <[Rory.Howe@cms.hhs.gov](mailto:Rory.Howe@cms.hhs.gov)>; DeCaro, Teresa (CMS/CMCS) <[teresa.decaro@cms.hhs.gov](mailto:teresa.decaro@cms.hhs.gov)>; Rashid, Mehreen (CMS/CMCS) <[mehreen.rashid@cms.hhs.gov](mailto:mehreen.rashid@cms.hhs.gov)>; Clark, Elizabeth (CMS/CMCS) <[Elizabeth.Clark@cms.hhs.gov](mailto:Elizabeth.Clark@cms.hhs.gov)>

**Cc:** HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>

**Subject:** RE: DSRIP questions

Thanks, Gary.

I'll actually ask the 1115 team to take a look at these, since they are related to a possible

amendment to the demonstration.

Judith

---

**From:** Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>

**Sent:** Monday, August 23, 2021 2:55 PM

**To:** Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers, Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; Bilse, Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>; Stephens, Stephanie (HHSC) <[Stephanie.Stephens01@hhs.texas.gov](mailto:Stephanie.Stephens01@hhs.texas.gov)>; Cash, Judith (CMS/CMCS) <[Judith.Cash@cms.hhs.gov](mailto:Judith.Cash@cms.hhs.gov)>; Deboy, Alissa M. (CMS/CMCS) <[alissa.deboy1@cms.hhs.gov](mailto:alissa.deboy1@cms.hhs.gov)>; Smith, Carrie A. (CMS/CMCS) <[Carrie.Smith@cms.hhs.gov](mailto:Carrie.Smith@cms.hhs.gov)>; Howe, Rory (CMS/CMCS) <[Rory.Howe@cms.hhs.gov](mailto:Rory.Howe@cms.hhs.gov)>; DeCaro, Teresa (CMS/CMCS) <[teresa.decaro@cms.hhs.gov](mailto:teresa.decaro@cms.hhs.gov)>; Rashid, Mehreen (CMS/CMCS) <[mehreen.rashid@cms.hhs.gov](mailto:mehreen.rashid@cms.hhs.gov)>; Clark, Elizabeth (CMS/CMCS) <[Elizabeth.Clark@cms.hhs.gov](mailto:Elizabeth.Clark@cms.hhs.gov)>

**Cc:** HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>

**Subject:** DSRIP questions

John and CMS Colleagues:

Texas has some questions regarding the DSRIP extension option and waiver amendment process. Please see the attached document.

Thanks.

Gary

---

**From:** Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>

**Sent:** Friday, August 20, 2021 9:49 AM

**To:** HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers, Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; Bilse, Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>; Stephens, Stephanie (HHSC) <[Stephanie.Stephens01@hhs.texas.gov](mailto:Stephanie.Stephens01@hhs.texas.gov)>; Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>; Cash, Judith (CMS/CMCS) <[Judith.Cash@cms.hhs.gov](mailto:Judith.Cash@cms.hhs.gov)>; Deboy, Alissa M. (CMS/CMCS) <[alissa.deboy1@cms.hhs.gov](mailto:alissa.deboy1@cms.hhs.gov)>; Smith, Carrie A. (CMS/CMCS) <[Carrie.Smith@cms.hhs.gov](mailto:Carrie.Smith@cms.hhs.gov)>; Howe, Rory (CMS/CMCS) <[Rory.Howe@cms.hhs.gov](mailto:Rory.Howe@cms.hhs.gov)>; DeCaro, Teresa (CMS/CMCS) <[teresa.decaro@cms.hhs.gov](mailto:teresa.decaro@cms.hhs.gov)>; Rashid, Mehreen (CMS/CMCS) <[mehreen.rashid@cms.hhs.gov](mailto:mehreen.rashid@cms.hhs.gov)>; Clark, Elizabeth (CMS/CMCS) <[Elizabeth.Clark@cms.hhs.gov](mailto:Elizabeth.Clark@cms.hhs.gov)>

**Subject:** Call with TX on SFY 2022 Preprints

**When:** Friday, August 20, 2021 12:00 PM-1:00 PM.

**Where:** <https://cms.zoomgov.com/j/1610257688?pwd=N0FBTHU2QTRZdWpVK21mWmpYL1Njdz09>

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John Giles is inviting you to a scheduled ZoomGov meeting.

Join ZoomGov Meeting

<https://cms.zoomgov.com/j/1610257688?pwd=N0FBTHU2QTRZdWpVK21mWmpYL1Njdz09>

Meeting ID: 161 025 7688

Password: 522776

One tap mobile

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Dial by your location

+1 669 254 5252 US (San Jose)

+1 646 828 7666 US (New York)

833 568 8864 US Toll-free

Meeting ID: 161 025 7688

Password: 522776

Find your local number: <https://cms.zoomgov.com/join/1610257688>

Join by SIP

Password: 522776

[sip:1610257688.522776@zoomgov.com](https://sip.1610257688.522776@zoomgov.com)

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**From:** [HHSC TX Medicaid Waivers](#)  
**To:** [Kristian, Diona \(CMS/CMCS\)](#); [Greenfield, Eli S. \(CMS/CMCS\)](#); [Blunt, Ford J. \(CMS/CMCS\)](#); [Branch, Jeoffrey A. \(CMS/CMCS\)](#)  
**Cc:** [Montalbano, Kathi \(HHSC\)](#); [Caruthers, Courtney \(HHSC\)](#); [Roland, Dawn \(HHSC\)](#)  
**Subject:** RE: 2021 Q3  
**Date:** Wednesday, August 25, 2021 11:23:38 AM  
**Attachments:** [image001.png](#)

---

Good morning, Diona,

Thank you!

Sincerely,

*Dawn M. Roland*

Dawn M. Roland, B.S.ED., CMP, CWM  
1915(c), 1915(b), 1915(i) Waivers Program Specialist II  
Policy Development Support  
Medicaid/CHIP Services  
**Texas Health and Human Services Commission**  
[Dawn.Roland@hhs.texas.gov](mailto:Dawn.Roland@hhs.texas.gov)



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---

**From:** Kristian, Diona (CMS/CMCS) <Diona.Kristian@cms.hhs.gov>  
**Sent:** Wednesday, August 25, 2021 10:14 AM  
**To:** HHSC TX Medicaid Waivers <TX\_Medicaid\_Waivers@hhs.texas.gov>; Greenfield, Eli S. (CMS/CMCS) <Eli.Greenfield@cms.hhs.gov>; Blunt, Ford J. (CMS/CMCS) <Ford.Blunt@cms.hhs.gov>; Jeoffrey Branch <Jeoffrey.Branch@CMS.hhs.gov>  
**Cc:** Montalbano, Kathi (HHSC) <Kathi.Montalbano@hhs.texas.gov>; Caruthers, Courtney (HHSC)

<Courtney.Caruthers@hhs.texas.gov>; Roland,Dawn (HHSC) <Dawn.Roland@hhs.texas.gov>

**Subject:** RE: 2021 Q3

**WARNING:** This email is from outside the HHS system. Do not click on links or attachments unless you expect them from the sender and know the content is safe.

Good Morning Dawn,

Thank you for emailing. I will create a slot for it in PMDA and get back to you when that is ready so that we can get it into PMDA.

Diona

---

**From:** HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>

**Sent:** Wednesday, August 25, 2021 9:59 AM

**To:** Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>; Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>; Blunt, Ford J. (CMS/CMCS) <[Ford.Blunt@cms.hhs.gov](mailto:Ford.Blunt@cms.hhs.gov)>; Branch, Jeoffrey A. (CMS/CMCS) <[Jeoffrey.Branch@cms.hhs.gov](mailto:Jeoffrey.Branch@cms.hhs.gov)>

**Cc:** Montalbano,Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers,Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; Roland,Dawn (HHSC) <[Dawn.Roland@hhs.texas.gov](mailto:Dawn.Roland@hhs.texas.gov)>

**Subject:** 2021 Q3

Good morning,

Please find attached the 2021 Q3 1115 Waiver Quarterly Payments and State Matching Share Summary Report which is due to CMS on August 27, 2021. This report is 37(b) in the STCs approved January 15, 2021.

We are sending this report via email as PMDA does not yet have a slot available for this. Please let us know when the PMDA has been updated and if you have other instructions in the meantime.

Sincerely,

*Dawn M. Roland*

Dawn M. Roland, B.S.ED., CMP, CWM  
1915(c), 1915(b), 1915(i) Waivers Program Specialist II  
Policy Development Support  
Medicaid/CHIP Services  
**Texas Health and Human Services Commission**  
**[Dawn.Roland@hhs.texas.gov](mailto:Dawn.Roland@hhs.texas.gov)**





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**From:** [Sentilles, Emily \(HHSC\)](#)  
**To:** [Kristian, Diona \(CMS/CMCS\)](#); [Greenfield, Eli S. \(CMS/CMCS\)](#); [Devoid, Isaac \(CMS/CMCS\)](#); [Frankos-Rev, Andrew \(CMS/CMCS\)](#); [Khan, Rabia \(CMS/CMCS\)](#); [Garner, Angela D. \(CMS/CMCS\)](#); [Marunycz, Lisa \(CMS/CMCS\)](#); [Blunt, Ford J. \(CMS/CMCS\)](#)  
**Cc:** [HHSC Texas Healthcare Transformation and Quality Improvement Program](#); [Vasquez, Andy \(HHSC\)](#)  
**Subject:** Texas Request for DSRIP COVID-19 Flexibilities  
**Date:** Wednesday, August 25, 2021 10:46:07 AM

---

Good morning, CMS Partners.

Per our conversation on Thursday, August 12, we respectfully request flexibility for DSRIP providers for Demonstration Year 10 in response to the ongoing COVID-19 pandemic. Category C performance year 4, calendar Year 2021, is quickly coming to a close and the DSRIP providers will not be able to pivot activities or performance with less than half a year left should the goals or structure of the program be changed. Providers are preparing for reporting on Category B in October of 2021. Therefore, HHSC is requesting the same flexibility that was granted for DY 9 for Category B and Category C.

- Please note, however, that we are not requesting provisional approvals that were approved for Category C or Category D.
- In addition, we would reduce the allowable variation from the Patient Population by Provider Category B from 35% in DY 9 to 10-15% in DY 10. This new allowable variation range is based on DY 9 data submitted by providers during the October 2020 and April 2021 reporting periods and national research on the decrease in utilization caused by COVID-19.

HHSC has conducted data analysis to ascertain the impact of COVID-19 on the DY9 DSRIP reporting that we have shared with you. To summarize, while there was an overall decrease in denominator populations and decrease in performance on Category C measures, there is not a clear pattern across the reported performance. In some instances, utilization increased (as observed in denominator populations in palliative care measures). But there is little rhyme or reason to the changes. HHSC conducted additional analysis to address the options CMS raised on our previous phone calls, such as if there were any trends in the DY9 reported data by region or provider type. Similarly, there were not clear trends in the data.

We had previously provided a data point that 36% of all reported measures used the DY 9 approved flexibilities. But that number does not equate to 36% of providers using the flexibility. In subsequent analysis, we have determined the percent of providers NOT using COVID accommodations for any reported measure to be the following:

Provider Type	% of Providers Not Using COVID Accommodations for Any Reported Measure
CMHC	34%
H	27%
LHD	31%

PP	13%
----	-----

In other words, upwards of 66% of each provider type used the DY 9 flexibilities for at least one of their reported measures. This demonstrates the extent of the impact of COVID-19 on the providers. Additionally, COVID-19 has continued to impact the DSRIP providers into the current calendar year, starting with the surge in January and now with the Delta variant.

We agree with CMS that DSRIP is an incentive program and our goal for the program, even while the pandemic rages, is for providers to improve the quality of care and transform the delivery system. We believe that the maintenance of the DY10 performance goals aligns with that intention. But the pandemic has upended the healthcare delivery system as we know it and created challenges in achieving quality measures across all programs.

Should CMS still desire to limit the approved flexibilities for DSRIP participating providers, HHSC would propose the following:

Require providers to request the flexibility for Cat C achievement. This would be an administrative step providers would need to follow in order to be granted the flexibility, instead of automatically allowing the flexibility. Upon request, HHSC would allow the same flexibility as for DY9:

- Approval for providers to earn payment for DY10 achievement milestones based on the higher of their approved DY8 achievement, the statewide average approved DY8 achievement per measure or measure bundle, or DY10 achievement in calendar year 2021. In Category C, the measurement year is a calendar year. Each measure in the Measure Bundle Protocol is in a defined measure bundle, a grouping of measures that share a unified theme, apply to a similar population, and are impacted by similar activities, such as diabetes measures or hospital safety measures.
- Using the average approved DY8 achievement per bundle for measure selections of less than 10 as the minimum payment for a provider's DY10 achievement milestone would reduce the impact of using an average achievement per measure on measures that have been selected by a low number of providers.
- Providers would be required to report calendar year 2021 data to be eligible for payment on the Category C DY10 achievement milestones.

Category B flexibility would remain in place for all providers without a specific request, but as mentioned above, would provide an allowable variation of 10-15%, lower than the amount approved for DY9.

Please let us know if you have questions or would like to discuss this on a call. We appreciate the time and assistance you have already provided us

exploring DY9 results and potential changes for DY 10. Thank you for considering this request.

Thank you,  
DSRIP Team

Emily Sentilles  
Director, Healthcare Transformation Waiver Programs  
Medicaid & CHIP Services

**From:** [Sentilles, Emily \(HHSC\)](#)  
**To:** [Kristian, Diona \(CMS/CMCS\)](#); [Greenfield, Eli S. \(CMS/CMCS\)](#); [Devoid, Isaac \(CMS/CMCS\)](#); [Frankos-Rev, Andrew \(CMS/CMCS\)](#); [Khan, Rabia \(CMS/CMCS\)](#); [Garner, Angela D. \(CMS/CMCS\)](#); [Marunycz, Lisa \(CMS/CMCS\)](#); [Blunt, Ford J. \(CMS/CMCS\)](#)  
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- In addition, we would reduce the allowable variation from the Patient Population by Provider Category B from 35% in DY 9 to 10-15% in DY 10. This new allowable variation range is based on DY 9 data submitted by providers during the October 2020 and April 2021 reporting periods and national research on the decrease in utilization caused by COVID-19.

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exploring DY9 results and potential changes for DY 10. Thank you for considering this request.

Thank you,  
DSRIP Team

Emily Sentilles  
Director, Healthcare Transformation Waiver Programs  
Medicaid & CHIP Services



**From:** [Roland, Dawn \(HHSC\)](#)  
**To:** [Kristian, Diona \(CMS/CMCS\)](#); [Greenfield, Eli S. \(CMS/CMCS\)](#); [Branch, Jeffrey A. \(CMS/CMCS\)](#)  
**Cc:** [Montalbano, Kathi \(HHSC\)](#); [Caruthers, Courtney \(HHSC\)](#); [Roland, Dawn \(HHSC\)](#)  
**Subject:** TX BN Workbook-THTQIP-1115 Q3  
**Date:** Wednesday, August 25, 2021 10:37:33 AM  
**Attachments:** [image001.png](#)  
[TX BN Workbook-THTQIP-1115 PMDA-20200724 v2.12 2021 Q3 v.xlsm](#)

---

Good morning,

This is to inform you that we have submitted the TX BN Workbook – THTQIP 1115 Q3 in PMDA and have attached the same file here for your ready reference.

Sincerely,

*Dawn M. Roland*

Dawn M. Roland, B.S.ED., CMP, CWM  
1915(c), 1915(b), 1915(i) Waivers Program Specialist II  
Policy Development Support  
Medicaid/CHIP Services  
**Texas Health and Human Services Commission**  
[Dawn.Roland@hhs.texas.gov](mailto:Dawn.Roland@hhs.texas.gov)



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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1148 (CMS-10398 #56)**. The time required to complete this information collection is estimated to average **7.5 hours** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Budget neutrality is a Federal policy that governs the Federal expenditures for 1115 demonstrations. It is assured by placing an upper limit on the amount of Federal Financial Participation (FFP) the state can receive during the demonstration. The upper limit represents what the state could have received in the absence of the 1115 demonstration.

The Budget Neutrality workbook will assist in collecting standardized data in order to determine financial performance for the demonstration in terms of budget neutrality.

The workbook has two major groups of tabs: the first group collects and calculates Without Waiver (WOW) numbers, and the second group calculates With Waiver (WW) numbers. Data is collected per each demonstration Medicaid Eligibility Group (MEG), by demonstration year (DY). A Medicaid section 1115 demonstration is considered budget neutral if the Federal title XIX match, or funding received by the state (i.e., "with waiver" expenditures) do not exceed what the state would have (or could have) received without the demonstration (i.e., "without waiver" expenditures). The workbook provides the ability to evaluate any variance between WW and WOW calculations.

The workbook consists of 15 tabs which contain different types of data and calculations. The following color schema is applied to the tabs:

Blue	Information populated in the Budget Neutrality workbook template based on the demonstration's approved STC
Red	Information populated by states on a quarterly basis or per the reporting requirements defined in the STC
Green	Information automatically populated based on the input from other worksheets

Note: Overview and Dropdowns tabs are read-only, no data entry is required. The Dropdowns tab displays the values used to build the dropdowns menus throughout the workbook, including the list of active waivers for the demonstration.

**Data Entry** Within the tabs where a State User populates information (C Report, Total Adjustments, WW Spending Projected, MemMon Actual, MemMon Projected, and Summary TC tabs), yellow highlighted cells denote where data entry may be needed (depending on DY being updated).

**Pre-populated values in the downloaded Budget Neutrality workbook template**

The original workbook entries are based on the STCs and other demonstration approval documentation. These entries are made on the DY Def, MEG Def, WOW PDM & Agg, Program Spending Limits, and Summary TC tab (Phase-Down Percentage and Cumulative Target Percentage fields).

The MEG Def tab defines MEGs as Medicaid populations (core demonstration populations), Hypothetical populations (when a demonstration has separate budget neutrality agreements) and Tracking Only populations (for example, "pass-through" populations). The MEG Def tab also defines how expenditure numbers are calculated for a MEG (Per Capita vs. Aggregate) and the applicable scenarios (WOW, WW, or both). Also, the tab contains indicators defining MEG characteristics such as expenditure caps or applicability of savings phase-down calculations.

**Calculating With Waiver (WW) numbers**

**Demonstration Years Definitions**

DY	1	2	3	4	5	6	7	8	9	10	11
Start Date	10/1/2011	10/1/2012	10/1/2013	10/1/2014	10/1/2015	10/1/2016	10/1/2017	10/1/2018	10/1/2019	10/1/2020	10/1/2021
End Date	9/30/2012	10/2/2012	9/30/2014	9/30/2015	9/30/2016	9/30/2017	9/30/2018	9/30/2019	9/30/2020	9/30/2021	9/30/2022



N/A  
N/A  
N/A

Tracking Only

**WOW PMPMs and Aggregates**

		7	8	9	10	11
<b>Medicaid Per Capita</b> <i>AMR</i> <i>Disabled</i> <i>Adults</i> <i>Children</i>	1	\$1,253.57	\$1,301.21	\$1,350.66	\$1,401.98	\$1,455.26
	2	\$1,723.19	\$1,793.84	\$1,867.39	\$1,943.96	\$2,023.66
	3	\$1,023.19	\$1,077.42	\$1,134.52	\$1,194.65	\$1,257.96
	4	\$347.08	\$362.70	\$379.02	\$396.07	\$413.90
<b>Medicaid Aggregate - WOW only</b> <i>UPL for Excluded Population</i> <i>UPL for Included Population</i> <i>Physician UPL</i> <i>Outpatient UPL</i>	1	\$1,681,649,843	\$1,681,649,843	\$1,681,649,843	\$1,681,649,843	\$1,681,649,843
	2	\$2,346,880,705	\$2,346,880,705	\$2,346,880,705	\$2,346,880,705	\$2,346,880,705
	3	\$84,237,473	\$84,237,473	\$84,237,473	\$84,237,473	\$84,237,473
	4	\$72,483,206	\$72,483,206	\$72,483,206	\$72,483,206	\$72,483,206

## Program Spending Limits

							TOTAL
Program Name and Associated MEGs	7	8	9	10	11		
Spending Cap							
UC Pool	\$3,101,776,278	\$3,101,776,278	\$2,346,880,705	\$2,346,880,705	\$2,346,880,705	\$	33,926,194,671
Expenditures Subject to Cap							
UC Pool	\$3,095,960,912	\$2,956,039,117	\$3,701,451,886	\$1,480,546,548			
Variance	\$5,815,366	\$145,737,161	(\$1,354,571,181)	\$866,334,157	\$2,346,880,705	\$	2,064,341,839
Over or Under			Over				

						TOTAL
Program Name and Associated MEGs						
Spending Cap						
<i>DSR/IP Pool</i>						\$ 26,118,000,000
Expenditures Subject to Cap						
<i>DSR/IP Pool</i>						
Variance						
Over or Under						

Case No. 6:21-cv-00191-JCB  
Page No. 79 of 592  
Printed: 9/24/2021 10:24:00 AM

Please all information related to the demonstration from Schedule C of the CMS 64 Waiver Expense Report.  
1. On this Schedule C Report, locate rows relevant to all expenditures for a specific demonstration.  
2. For each row, enter the amount of the expenditure in the appropriate column (A (Waiver Name)).  
3. Add Waiver's Total Composites section -- into cell A00.  
4. Add Waiver's Federal Share section -- into cell A00.  
5. Add Waiver's Total Composites section -- into cell A00.  
6. Add Waiver's Federal Share section -- into cell A00.  
7. Add Waiver's Total Composites section -- into cell A00.  
8. Add Waiver's Federal Share section -- into cell A00.

**MAP Waiver**

Total Composite		Waiver Name		A		01		02		03		04		05		06		07		08		09		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30		Total		Total Loss		Non-Add	
01		02		03		04		05		06		07		08		09		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30		Total <td colspan="2">Total Loss<td colspan="2">Non-Add</td></td>		Total Loss <td colspan="2">Non-Add</td>		Non-Add							
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01		02		03		04		05		06		07		08		09		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30		Total <td colspan="2">Total Loss<td colspan="2">Non-Add</td></td>		Total Loss <td colspan="2">Non-Add</td>		Non-Add							
01		02		03		04		05		06		07		08		09		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30		Total <td colspan="2">Total Loss<td colspan="2">Non-Add</td></td>		Total Loss <td colspan="2">Non-Add</td>		Non-Add							
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01		02		03		04		05		06		07		08		09		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30		Total <td colspan="2">Total Loss<td colspan="2">Non-Add</td></td>		Total Loss <td colspan="2">Non-Add</td>		Non-Add							
01		02		03		04		05		06		07		08		09		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30		Total <td colspan="2">Total Loss<td colspan="2">Non-Add</td></td>		Total Loss <td colspan="2">Non-Add</td>		Non-Add							
01		02		03		04		05		06		07		08		09		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30		Total <td colspan="2">Total Loss<td colspan="2">Non-Add</td></td>		Total Loss <td colspan="2">Non-Add</td>		Non-Add							
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01		02		03		04		05		06		07		08		09		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30		Total <td colspan="2">Total Loss<td colspan="2">Non-</td></td>		Total Loss <td colspan="2">Non-</td>		Non-							



## C Report Grouper

## MAP Waivers Only

Total Computable										
MEG Names		C Report Waiver Names								
<u>Medicaid Per Capita</u>										
AMR	1	THQTIP-AMR	\$4,731,736,942	\$5,193,221,191	\$5,577,339,137	\$4,336,985,289				
Disabled	2	THQTIP-Disabled	\$8,292,569,566	\$9,078,653,424	\$9,438,194,205	\$7,503,620,597				
Adults	3	THQTIP-Adults	\$2,268,910,396	\$2,496,068,419	\$2,837,226,272	\$3,416,395,133				
Children	4	THQTIP-Children	\$8,160,455,897	\$8,471,218,231	\$9,012,123,307	\$8,324,016,174				
Children	4	THQTIP-M-CHIP	\$554							
Children	4	64.21U & 64.21UP THQTIP-Qualified	\$80							
<u>Medicaid Aggregate - VWW only</u>										
UC Pool	1	THQTIP-UC	\$3,095,960,912	\$2,956,039,117	\$3,701,451,886	\$1,480,546,548				
UC Pool	1	THQTIP-UC UPL								
DSRIP Pool	2	THQTIP-DSRIP	\$2,992,698,237	\$2,744,424,267	\$726,154,442					
<b>TOTAL</b>			\$ 29,542,332,384	\$ 30,939,624,649	\$ 31,292,489,249	\$ 25,061,563,741	\$			-

**Adjustments made to the reported expenditures**

Enter total adjustments made to the expenditure numbers, including adjustments to the previous reporting periods.

Positive adjustments increase expenditures, and negative adjustments decrease expenditures.

Enter adjustments for every MEG for which adjustments were made or are planned.

**Helpful Hint:** Remember to enter total adjustments as positive or negative (for example, -\$10,000 reflects a decrease in expenditures).

		7	8	9	10	11	Description (type of collection, time period, CMS-64 reporting line, etc.)
<u><b>Medicaid Per Capita</b></u> AMR Disabled Adults Children	1						ACA HIPF
	2		-\$1,925,866				ACA HIPF
	3		-\$118,937,982				ACA HIPF
	4		-\$30,357,976				ACA HIPF
<u><b>Medicaid Aggregate - WW only</b></u> UC Pool DSRIP Pool	1						
	2						

## WW Spending - Actual

Total Computable

		7	8	9	10	11
<u>Medicaid Per Capita</u>						
1	AMR	\$4,731,736,942	\$5,191,295,325	\$5,577,339,137	\$4,336,985,289	
2	Disabled	\$8,292,569,566	\$8,959,715,442	\$9,438,194,205	\$7,503,620,597	
3	Adults	\$2,268,910,396	\$2,465,710,443	\$2,837,226,272	\$3,416,395,133	
4	Children	\$8,160,456,331	\$8,365,580,952	\$9,012,123,307	\$8,324,016,174	
<u>Medicaid Aggregate - WW only</u>						
1	UC Pool	\$3,095,960,912	\$2,956,039,117	\$3,701,451,886	\$1,480,546,548	
2	DSRIP Pool	\$2,992,698,237	\$2,744,424,267	\$726,154,442		
<b>TOTAL</b>		<b>\$ 29,542,332,384</b>	<b>\$ 30,682,765,546</b>	<b>\$ 31,292,489,249</b>	<b>\$ 25,061,563,741</b>	<b>\$ -</b>

**WW Spending - Projected**

Enter projected spending for the demonstration which includes the remaining quarters of the current DY and all future DYs.

Enter the projected annual expenditures for each DY per MEG for the active DYs.

For the current DY, only future quarters should have projected spending information. Do not include expenditures that were reported as actuals.

<b>Total Computable</b>		7	8	9	10	11
<b><u>Medicaid Per Capita</u></b>		1				
AMR					\$1,395,415,645	\$ 6,196,586,170
Disabled		2			\$2,489,012,449	\$ 11,028,101,236
Adults		3			\$952,611,044	\$ 3,150,840,046
Children		4			\$2,361,968,541	\$ 10,206,965,140
<b><u>Medicaid Aggregate - WW only</u></b>						
UC Pool		1			\$2,392,659,645	\$ 3,873,206,193
DSRIP Pool		2			\$2,490,000,000	\$ -

BNIOK

**WW Spending - Total****Total Computable**

		7	8	9	10	11
<b><u>Medicaid Per Capita</u></b>						
AMR	1	\$4,731,736,942	\$5,191,295,325	\$5,577,339,137	\$5,732,400,934	\$6,196,586,170
Disabled	2	\$8,292,569,566	\$8,959,715,442	\$9,438,194,205	\$9,992,633,046	\$11,028,101,236
Adults	3	\$2,268,910,396	\$2,465,710,443	\$2,837,226,272	\$4,369,006,177	\$3,150,840,046
<b><u>Medicaid Aggregate - WW only</u></b>						
UC Pool	1	\$3,095,960,912	\$2,956,039,117	\$3,701,451,886	\$3,873,206,193	\$3,873,206,193
DSRIP Pool	2	\$2,992,698,237	\$2,744,424,267	\$726,154,442	\$2,490,000,000	
<b>TOTAL</b>		<b>\$ 29,542,332,384</b>	<b>\$ 30,682,765,546</b>	<b>\$ 31,292,489,249</b>	<b>\$ 37,143,231,064</b>	<b>\$ 34,455,698,786</b>

**Member Months - Actual**

Enter actual member months (number of beneficiaries times the number of enrolled months) for quarters to date for each active DY.  
 For the reported quarter, add the actual number of member months per each MEG to the previous actual number. The number should equal the total of ALL actual member months for the reported quarter.  
**Note:** Depending of the specifics of the state, you can use Total member months or Average monthly unduplicated counts. Whichever definition is used, it must be applied consistently across all quarters.  
**Helpful Hint:** When updating a DY, remember to enter actual member months for the reported quarter along with actuals for prior quarter(s). Retroactive adjustments may be made to prior quarters.

		7	8	9	10	11
<b><u>Medicaid Per Capita</u></b>						
AMR	1	4,269,502	4,253,307	4,275,480	3,151,307	
Disabled	2	4,990,565	4,898,960	4,884,022	3,750,886	
Adults	3	3,416,904	3,275,131	3,613,597	4,038,309	
Children	4	31,614,307	30,691,208	31,808,171	27,439,364	

**Member Months - Projected**

Enter/adjust projected member months based on reported actuals.  
 Enter projected number of member months for each active DY per MEG for the demonstration.  
 For the current DY, enter only the number that reflects projections for future quarters of the DY.  
 Do not include member months for either the current reporting quarter or past quarters.

		7	8	9	10	11
<b><u>Medicaid Per Capita</u></b> AMR Disabled Adults Children	1				1062763	4,348,666
	2				1279754	5,151,745
	3				1619368	3,366,107
	4				9903493	32,945,528

## Member Months - Total

		7	8	9	10	11
<u>Medicaid Per Capita</u>						
AMR	1	4,269,502	4,253,307	4,275,480	4,214,070	4,348,666
Disabled	2	4,990,565	4,898,960	4,884,022	5,030,640	5,151,745
Adults	3	3,416,904	3,275,131	3,613,597	5,657,677	3,366,107
Children	4	31,614,307	30,691,208	31,808,171	37,342,858	32,945,528



**Budget Neutrality Summary**

The Budget Neutrality Reporting Period dropdown menu allows for selection of a specific reporting period, by Demonstration Year. By changing these settings, you change the view for which Demonstration Years will be used in calculating Budget Neutrality. Selecting the 'Reset to Defaults' button will reset the Reporting DY values back to the demonstration's current Period of Performance.

Budget Neutrality Reporting Start DY	7
Budget Neutrality Reporting End DY	11

Actuals + Projected
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Without-Waiver Total Expenditures		7	8	9	10	11	Total
Medicaid Per Capita	AMR	1	\$ 5,352,119,104 \$	\$ 5,534,445,481 \$	\$ 5,774,720,248 \$	\$ 5,908,042,151 \$	\$ 6,328,440,069 \$
			\$ 1,253,57	\$ 1,301,21	\$ 1,350,66	\$ 1,401,98	\$ 1,455,26
			\$ 4,269,502	\$ 4,253,307	\$ 4,275,480	\$ 4,214,070	\$ 4,348,666
	Total		\$ 8,599,691,481 \$	\$ 8,787,950,011 \$	\$ 9,120,374,109 \$	\$ 9,779,362,527 \$	\$ 10,425,379,628 \$
Disabled		2	\$ 1,723,19	\$ 1,793,84	\$ 1,867,39	\$ 1,943,96	\$ 2,023,66
			\$ 4,990,565	\$ 4,898,960	\$ 4,884,022	\$ 5,030,640	\$ 5,151,745
	Total		\$ 3,496,142,004 \$	\$ 3,528,691,642 \$	\$ 4,099,698,460 \$	\$ 6,758,943,474 \$	\$ 4,234,428,578 \$
	Mem-Mon		\$ 1,023,19	\$ 1,077,42	\$ 1,134,52	\$ 1,194,65	\$ 1,257,96
Adults		3	\$ 3,416,904	\$ 3,275,131	\$ 3,613,597	\$ 5,657,677	\$ 3,366,107
	Total		\$ 10,972,693,674 \$	\$ 11,131,701,142 \$	\$ 12,055,933,064 \$	\$ 14,790,385,621 \$	\$ 13,636,154,133
	Mem-Mon		\$ 347,08	\$ 362,70	\$ 379,02	\$ 396,07	\$ 413,90
	Total		\$ 31,614,307	\$ 30,691,208	\$ 31,808,171	\$ 37,342,858	\$ 32,945,528
Children		4	\$ 1,681,649,843 \$	\$ 1,681,649,843 \$	\$ 1,681,649,843 \$	\$ 1,681,649,843 \$	\$ 1,681,649,843 \$
			\$ 2,346,880,705 \$	\$ 2,346,880,705 \$	\$ 2,346,880,705 \$	\$ 2,346,880,705 \$	\$ 2,346,880,705 \$
	Total		\$ 84,237,473 \$	\$ 84,237,473 \$	\$ 84,237,473 \$	\$ 84,237,473 \$	\$ 84,237,473 \$
	Mem-Mon		\$ 72,483,206 \$	\$ 72,483,206 \$	\$ 72,483,206 \$	\$ 72,483,206 \$	\$ 72,483,206 \$
TOTAL			\$ 32,605,897,489 \$	\$ 33,168,039,502 \$	\$ 35,235,977,108 \$	\$ 41,421,985,000 \$	\$ 38,809,653,634 \$
							\$ 181,241,562,734

With-Waiver Total Expenditures		7	8	9	10	11	TOTAL
Medicaid Per Capita	AMR	1	\$ 4,731,736,942 \$	\$ 5,191,295,325 \$	\$ 5,577,339,137 \$	\$ 5,732,400,934 \$	\$ 6,196,586,170 \$
	Disabled	2	\$ 8,292,569,566 \$	\$ 8,959,715,442 \$	\$ 9,438,194,205 \$	\$ 9,992,633,046 \$	\$ 11,028,101,236 \$
	Adults	3	\$ 2,268,910,396 \$	\$ 2,465,710,443 \$	\$ 2,837,226,272 \$	\$ 4,369,006,177 \$	\$ 3,150,840,046 \$
	Children	4	\$ 8,160,456,331 \$	\$ 8,365,580,952 \$	\$ 9,012,123,307 \$	\$ 10,685,984,715 \$	\$ 10,206,965,140 \$
Medicaid Aggregate - WW only	UC Pool	1	\$ 3,095,960,912 \$	\$ 2,956,039,117 \$	\$ 3,701,451,886 \$	\$ 3,873,206,193 \$	\$ 3,873,206,193 \$
	DSRIP Pool	2	\$ 2,992,688,237 \$	\$ 2,744,424,267 \$	\$ 726,154,442 \$	\$ 2,490,000,000 \$	\$ -
	Total		\$ 29,542,332,384 \$	\$ 30,682,765,546 \$	\$ 31,292,489,249 \$	\$ 37,143,231,064 \$	\$ 34,455,698,786 \$
	TOTAL						\$ 163,116,517,028

Savings Phase-Down		7	8	9	10	11	TOTAL
Medicaid Per Capita	AMR	1	\$ 5,352,119,104 \$	\$ 5,534,445,481 \$	\$ 5,774,720,248 \$	\$ 5,908,042,151 \$	\$ 6,328,440,069 \$
	Disabled	2	\$ 4,731,736,942 \$	\$ 5,191,295,325 \$	\$ 5,577,339,137 \$	\$ 5,732,400,934 \$	\$ 6,196,586,170 \$
	Adults	3	\$ 620,382,162 \$	\$ 343,150,155 \$	\$ 197,381,111 \$	\$ 175,641,218 \$	\$ 131,853,899 \$
	Children	4	\$ 86,853,503 \$	\$ 58,335,526 \$	\$ 47,371,467 \$	\$ 56,205,190 \$	\$ 52,741,559 \$
Medicaid Aggregate - WW only	UC Pool	1	\$ 3,095,960,912 \$	\$ 2,956,039,117 \$	\$ 3,701,451,886 \$	\$ 3,873,206,193 \$	\$ 3,873,206,193 \$
	DSRIP Pool	2	\$ 2,992,688,237 \$	\$ 2,744,424,267 \$	\$ 726,154,442 \$	\$ 2,490,000,000 \$	\$ -
	Total		\$ 29,542,332,384 \$	\$ 30,682,765,546 \$	\$ 31,292,489,249 \$	\$ 37,143,231,064 \$	\$ 34,455,698,786 \$
	TOTAL						\$ 163,116,517,028

Difference Phase-Down Percentage Savings Reduction		With Waiver	\$ 8,292,569,566 \$ 8,959,715,442 \$ 9,438,194,205 \$ 9,992,633,046 \$ 11,028,101,236
			\$ 307,121,915 \$ (171,765,430) \$ (317,820,096) \$ (213,270,518) \$ (602,721,608)
			\$ 55,281,945 \$ - \$ - \$ 69% \$ 61%
Adults	3	<i>Savings Phase-Down</i> <b>Without Waiver</b> <b>With Waiver</b>	\$ 3,496,142,004 \$ 3,528,691,642 \$ 4,098,698,460 \$ 6,758,943,474 \$ 4,234,428,578
			\$ 2,268,910,396 \$ 2,465,710,443 \$ 2,837,226,272 \$ 4,369,006,177 \$ 3,150,840,046
Difference Phase-Down Percentage Savings Reduction			\$ 1,227,231,608 \$ 1,062,981,199 \$ 1,262,472,188 \$ 2,389,937,298 \$ 1,083,588,532
			\$ 52% 48% 44% 41% 37%
Children	4	<i>Savings Phase-Down</i> <b>Without Waiver</b> <b>With Waiver</b>	\$ 589,071,172 \$ 552,750,223 \$ 706,984,425 \$ 1,410,063,006 \$ 682,660,775
			\$ 10,972,693,674 \$ 11,131,701,142 \$ 12,055,933,064 \$ 14,790,385,621 \$ 13,636,154,133
Difference Phase-Down Percentage Savings Reduction			\$ 8,160,456,331 \$ 8,365,580,952 \$ 9,012,123,307 \$ 10,685,984,715 \$ 10,206,965,140
			\$ 2,812,237,343 \$ 2,766,120,190 \$ 3,043,809,757 \$ 4,104,400,906 \$ 3,429,188,993
			\$ 60% 55% 49% 43% 38%
<b>Total Reduction</b>			\$ 1,124,894,937 \$ 1,244,754,085 \$ 1,552,342,976 \$ 2,339,508,516 \$ 2,126,097,176
			\$ 1,856,101,556 \$ 1,855,839,835 \$ 2,306,698,868 \$ 3,805,776,712 \$ 2,861,499,510
			\$ 12,685,916,481

<b>BASE VARIANCE</b> <b>Excess Spending from Hypotheticals</b> 1115A Dual Demonstration Savings (state preliminary estimate) 1115A Dual Demonstration Savings (OACT certified) <b>Carry-Forward Savings From Prior Period</b> <b>NET VARIANCE</b>			\$ 1,207,463,549 \$ 629,434,121 \$ 1,636,788,991 \$ 472,977,225 \$ 1,492,455,339
			\$ (27,227,018) \$ (28,477,412) \$ (30,659,585) \$ (30,691,974) \$ (32,314,270)
			\$ (63,006,244) \$ (86,364,016) \$ 5,289,748,965

**Cumulative Target Limit**

			7	8	9	10	11

<u>Yes</u>	<u>No</u>	<u>Demonstration Reporting Start DY</u>	<u>Demonstration Reporting End DY</u>
7	11		
<b>MAP WAIVERS</b>			
Not Applicable			
64.21U & 64.21UP THTQIP-Qualified			
THTQIP 217-like AMR			
THTQIP 217-like Disabled			
THTQIP-Adults			
THTQIP-AMR			
THTQIP-Children			
THTQIP-Disabled			
THTQIP-DS RIP			
THTQIP-M-CHIP			
THTQIP-UC			
THTQIP-UC UPL			
<b>ADM WAIVERS</b>			
<b>Actuals Only</b>			
Actuals + Projected			
<b>Reporting Net Variance</b>			
\$ 5,289,748,965			
<b>Phase-Down</b>			
No Phase-Down			
Savings Phase-Down			
<b>Actuals and Projected</b>			
Actuals Only			
Actuals + Projected			
<b>MAP ADM</b>			
MAP+ADM Waivers			
MAP Waivers Only			

**From:** [HHSC TX Medicaid Waivers](#)  
**To:** [Greenfield, Eli S. \(CMS/CMCS\)](#); [Kristian, Diona \(CMS/CMCS\)](#); [Blunt, Ford J. \(CMS/CMCS\)](#); [Branch, Jeffrey A. \(CMS/CMCS\)](#)  
**Cc:** [Montalbano, Kathi \(HHSC\)](#); [Caruthers, Courtney \(HHSC\)](#); [Roland, Dawn \(HHSC\)](#)  
**Subject:** 2021 Q3  
**Date:** Wednesday, August 25, 2021 9:59:48 AM  
**Attachments:** [image001.png](#)  
[2021 Q3 1115 Waiver Quarterly Payments and State Share Source STC 37b.xlsx](#)

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Good morning,

Please find attached the 2021 Q3 1115 Waiver Quarterly Payments and State Matching Share Summary Report which is due to CMS on August 27, 2021. This report is 37(b) in the STCs approved January 15, 2021.

We are sending this report via email as PMDA does not yet have a slot available for this. Please let us know when the PMDA has been updated and if you have other instructions in the meantime.

Sincerely,

*Dawn M. Roland*

Dawn M. Roland, B.S.ED., CMP, CWM  
1915(c), 1915(b), 1915(i) Waivers Program Specialist II  
Policy Development Support  
Medicaid/CHIP Services  
**Texas Health and Human Services Commission**  
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TEXAS HEALTH AND HUMAN SERVICES COMMISSION  
1115 WAIVER QUARTERLY PAYMENTS AND STATE MATCHING SHARE SUMMARY  
STC 37(b)  
FY 2021 Q3

**FFY 2021 1115 Waiver - Payments and State Shares**  
**DSRIP, UC Hospital/Physician, UC Ambulance and UC Dental Program Summary**  
**Paid 2021 Q3 (April - June 2021)**

All UC Federal Categories	Total DSRIP Program	UC Dental	UC Ambulance	UC Hospital & Physician	Quarterly Total
All Funds Waiver Payments	\$ -	\$ 339,049.00	\$ -	\$ 156,597,478.68	\$ 156,936,527.68
State	\$ -	\$ 116,836.29	\$ -	\$ 68,621,015.16	\$ 68,737,851.45
Federal	\$ -	\$ 222,212.71	\$ -	\$ 87,976,463.52	\$ 88,198,676.23
Accounts Receivable - All Funds	\$ (3,140,455.86)	\$ -	\$ -	\$ 4,862,232.11	\$ 1,721,776.25
Accounts Receivable - State	\$ (1,085,403.71)	\$ -	\$ -	\$ 1,980,096.46	\$ 894,692.76
Accounts Receivable - Federal	\$ (2,055,052.15)	\$ -	\$ -	\$ 2,882,135.65	\$ 827,083.49
Total Waiver Payments (Including Adjustments)	\$ (\$3,140,455.86)	\$ 339,049.00	\$ -	\$ 161,459,710.79	\$ 158,658,303.93
Total State (Including Adjustments)	\$ (\$1,085,403.71)	\$ 116,836.29	\$ -	\$ 70,601,111.62	\$ 69,632,544.21
Total Federal (Including Adjustments)	\$ (\$2,055,052.15)	\$ 222,212.71	\$ -	\$ 90,858,599.17	\$ 89,025,759.72

TEXAS HEALTH AND HUMAN SERVICES COMMISSION  
 1115 WAIVER QUARTERLY PAYMENTS AND STATE MATCHING SHARE SUMMARY  
 STC 37(b)  
 FY 2021 Q3  
 Delivery System Reform Incentive Program (DSRIP)

**FFY 2021 Delivery System Reform Incentive Payment (DSRIP) Program - Payments and State Shares**  
**Paid 2021 Q3 (April - June 2021)**

All DSRIP Federal Categories	DSRIP Program
Gross All Funds Waiver Payments	\$ -
Gross State Share	\$ -
Gross Federal	\$ -
Accounts Receivable - All Funds	\$ (3,140,456)
Accounts Receivable - State	\$ (1,085,404)
Accounts Receivable - Federal	\$ (2,055,052)
Net All Funds Waiver Payments	\$ (3,140,456)
Net State	\$ (1,085,404)
Net Federal	\$ (2,055,052)

HEALTH AND HUMAN SERVICES COMMISSION  
WAIVER TRANSITIONAL PAYMENTS AND STATE MATCHING SHARE SUMMARY  
STC 37(b)  
FY 2021 Q3  
Delivery System Reform Incentive Program (DSRIP) Payment Detail

DY	Affiliation Number	DSRIP Provider	Govt Affiliation	Match Source of State	IGT Total DSRIP Pd 3Q21	Payment Total DSRIP Pd 3Q21
There were not any DSRIP payments made in 3Q21.						
					\$ -	\$ -

Total State Share	\$ -
Total Federal Share	\$ -
Total Paid	\$ -
<b>Payment Totals</b>	

TEXAS HEALTH AND HUMAN SERVICES COMMISSION  
1115 WAIVER QUARTERLY PAYMENTS AND STATE MATCHING SHARE SUMMARY  
STC 37(b)  
FY 2021 Q3  
Uncompensated Care (UC) Program - Hospitals and Physicians

**FFY 2021 Waiver Uncompensated Care (UC) Hospital and Physician Payments and State Shares**

**Paid 2021 Q3 (April - June 2021)**

All UC Federal Categories	UC Hospital / Physician	UC Ambulance	UC Dental	Total UC Programs - 2021 Q3
Gross All Funds Waiver Payments	\$ 156,597,479	\$ -	\$ 339,049	\$ 156,936,528
Gross State Share	\$ 68,621,015	\$ -	\$ 116,836	\$ 68,737,851
Gross Federal	\$ 87,976,464	\$ -	\$ 222,213	\$ 88,198,676
Accounts Receivable - All Funds	\$ (4,862,232)	\$ -	\$ -	\$ (4,862,232)
Accounts Receivable - State	\$ (1,980,096)	\$ -	\$ -	\$ (1,980,096)
Accounts Receivable - Federal	\$ (2,882,136)	\$ -	\$ -	\$ (2,882,136)
Net All Funds Waiver Payments	\$ 151,735,247	\$ -	\$ 339,049	\$ 152,074,296
Net State	\$ 66,640,919	\$ -	\$ 116,836	\$ 66,757,755
Net Federal	\$ 85,094,328	\$ -	\$ 222,213	\$ 85,316,541



TEXAS HEALTH AND HUMAN SERVICES COMMISSION  
1115 WAIVER QUARTERLY PAYMENTS AND STATE MATCHING SHARE SUMMARY  
STC 37(b)  
FY 2021 Q3  
Uncompensated Care (UC) Program - Hospitals/Physicians Payment Detail

DY	Affiliation Number	Provider	Govt Affiliation	Federal Category of Service	Source of State Match	IGT Total Pd 3Q21	Payment Total Pd 3Q21
6	450-19-0008-00018	ARMC-LP dba Abilene Regional Medical Center	Gregg County LPPF	Private	IGT	\$ 75,358.14	\$ 171,972.02
6	450-19-0008-00182	Baptist Hosp of SE TX dba Mem Hermann Bapt Beaumon	City of Beaumont LPPF	Private	IGT	\$ 52,548.48	\$ 119,918.94
6	450-19-0007-00062	Baylor Medical Center Irving	Dallas County Hosp Dist dba Parkland Health & Human LPPF	Private	IGT	\$ 83,133.42	\$ 189,715.70
6	450-19-0008-00005	Big Bend Hosp Corp Big Bend Reg Medical Center	Bell County LPPF Fund	Private	IGT	\$ 5,731.23	\$ 13,079.02
6	450-19-0008-00055	Burleson St Joseph Health Center of Caldwell	Brazos County dba Brazos County LPPF	Private	IGT	\$ 2,602.89	\$ 5,939.96
6	600-12-0000-00239	Christus Health ARK-LA-TEX dba Christus St. Michael HS	Atlanta Hospital Authority dba Atlanta Memorial Hospital	Private	IGT	\$ 102,914.32	\$ 234,856.96
6	450-19-0008-00183	Christus Health Southeast Texas dba Christus Jaspe	City of Beaumont LPPF	Private	IGT	\$ 16,807.34	\$ 38,355.41
6	600-12-0000-00094	Christus Spohn Hospital Alice	Nueces County Hospital District	Private	IGT	\$ 27,721.75	\$ 63,262.78
6	600-12-0000-00092	Christus Spohn Hospital Beeville	Nueces County Hospital District	Private	IGT	\$ 12,281.47	\$ 28,027.08
6	529-08-0236-00026	Crosbyton Clinic Hospital	Crosby County Hospital District	Private	IGT	\$ 1,317.01	\$ 3,005.50
6	529-08-0236-00051	Fort Duncan Medical Center	Maverick County Hospital District	Private	IGT	\$ 66,981.95	\$ 152,857.03
6	800-12-0000-00037	Gainesville Memorial Hospital	Gainesville Memorial Hospital	Private	IGT	\$ 13,652.56	\$ 31,156.00
6	450-19-0007-00044	Harris Methodist Southwest Hospital	Tarrant County Hospital Dist JPS (LPPF)	Private	IGT	\$ 132,650.70	\$ 302,717.25
6	450-19-0008-00023	Lake Granbury Medical Center	Gregg County LPPF	Private	IGT	\$ 64,966.31	\$ 148,257.21
6	450-19-0008-00051	Madison St Joseph Health Center	Brazos County dba Brazos County LPPF	Private	IGT	\$ 5,518.20	\$ 12,592.88
6	450-19-0007-00205	McAllen Hospitals LP dba Edinburg Regional Medical	Hidalgo County dba Hidalgo Cnty HCFD LPPF	Private	IGT	\$ 208,154.74	\$ 475,022.23
6	450-19-0007-00168	Memorial Hospital of Polk County dba Mem Med Ctr L	Angelina County dba Angelina County LPPF	Private	IGT	\$ 29,563.23	\$ 67,465.15
6	450-20-0011-00000	Metrolplex Adventist Hosp Inc dba Rollins Brook Com	Bell County LPPF Fund	Private	IGT	\$ 3,988.43	\$ 9,101.85
6	450-21-0004-00002	Mexia Principal Healthcare Ltd dba Parkview Region	Ellis County LPPF	Private	IGT	\$ 68,840.01	\$ 157,097.23
6	450-19-0008-00025	Navarro Hospital LP dba Navarro Regional Hospital	Gregg County LPPF	Private	IGT	\$ 62,255.47	\$ 142,070.90
6	600-18-0012-00002	Palacios Community Medical Center	West Wharton County Hospital District dba El Campo Mem Hosp	Private	IGT	\$ 465.00	\$ 1,061.16
6	450-21-0004-00001	Palastine Principle Healthcare LP dba Palestine Re	Ellis County LPPF	Private	IGT	\$ 169,701.25	\$ 387,268.93
6	600-12-0000-00203	Preferred Hospital Leasing Coleman Inc.	Coleman County Medical Center	Private	IGT	\$ 5,151.94	\$ 11,757.05
6	600-12-0000-00213	Preferred Hospital Leasing Hemphill Inc	Sabine County Hospital District	Private	IGT	\$ 1,756.19	\$ 4,007.74
6	529-09-0125-00012	Preferred Hospital Leasing Junction, Inc dba Kimble Hospital	Kimble County Hospital District	Private	IGT	\$ 1,725.05	\$ 3,936.67
6	600-16-0001-00018	Preferred Hospital Leasing Muleshoe Inc	Muleshoe Area Hospital District dba Muleshoe Area Medical Cen	Private	IGT	\$ 2,004.52	\$ 4,574.43
6	450-19-0008-00009	Scott & White Hospital - Marble Falls	Bell County LPPF Fund	Private	IGT	\$ 16,305.55	\$ 37,210.29
6	450-19-0007-00096	Scott & White Hospital - Taylor	Williamson County (LPPF)	Private	IGT	\$ 8,693.13	\$ 19,838.26
6	450-19-0008-00179	Seton Family of Hospitals dba Seton Edgar B Davis	Hays County Tax Assessor LPPF	Private	IGT	\$ 3,316.14	\$ 7,567.63
6	450-19-0007-00092	Seton Highland Lakes	McLennan County (LPPF)	Private	IGT	\$ 5,820.42	\$ 13,282.57
6	450-19-0007-00094	Shannon Medical Center	Tom Green County (LPPF)	Private	IGT	\$ 297,302.42	\$ 678,462.84
6	600-18-0007-00000	TH Healthcare Ltd dba Nacogdoches Med Ctr	El Paso County Hospital District	Private	IGT	\$ 42,291.83	\$ 96,512.62
6	450-19-0007-00091	Woodland Heights Medical Center	Angelina County dba Angelina County LPPF	Private	IGT	\$ 106,781.15	\$ 243,681.31
6	450-19-0007-00138	Athens Hospital LLC	Smith County LPPF	Private	IGT	\$ 107,326.11	\$ 244,924.94
6	529-08-0236-00003	Baptist Medical Center	Bexar County Hospital District (Univ Hlth Sys)	Private	IGT	\$ 652,856.04	\$ 1,489,858.60
6	450-19-0007-00088	Baptist St Anthonys Hospital	Amarillo Hospital District LPPF	Private	IGT	\$ 270,734.66	\$ 617,833.54
6	450-19-0007-00037	Baylor All Saints Medical Center	Tarrant County Hospital Dist JPS (LPPF)	Private	IGT	\$ 120,722.53	\$ 275,496.42
6	450-19-0007-00067	Baylor Heart & Vascular Center LLP	Dallas County Hosp Dist dba Parkland Health & Human LPPF	Private	IGT	\$ 10,968.40	\$ 25,030.57
6	450-19-0007-00084	Baylor Med Ctr Garland & McKinney dba BSW Med Ctr	Dallas County Hosp Dist dba Parkland Health & Human LPPF	Private	IGT	\$ 55,556.04	\$ 126,786.95
6	450-19-0008-00170	Baylor Medical Center at Waxahachie	Ellis County LPPF	Private	IGT	\$ 31,556.11	\$ 72,013.03
6	450-19-0007-00038	Baylor Regional Medical Center at Grapevine	Tarrant County Hospital Dist JPS (LPPF)	Private	IGT	\$ 39,293.28	\$ 89,669.74
6	450-19-0007-00080	Baylor Regional Medical Center at Plano	Dallas County Hosp Dist dba Parkland Health & Human LPPF	Private	IGT	\$ 21,933.10	\$ 50,052.71
6	450-19-0007-00066	Baylor University Medical Center	Dallas County Hosp Dist dba Parkland Health & Human LPPF	Private	IGT	\$ 515,464.97	\$ 1,176,323.52

TEXAS HEALTH AND HUMAN SERVICES COMMISSION  
1115 WAIVER QUARTERLY PAYMENTS AND STATE MATCHING SHARE SUMMARY  
STC 37(b)  
FY 2021 Q3  
Uncompensated Care (UC) Program - Hospitals/Physicians Payment Detail

DY	Affiliation Number	Provider	Govt Affiliation	Federal Category of Service	Source of State Match	IGT Total Pd 3Q21	Payment Total Pd 3Q21
6	100-20-0005-00000	Bosque County Hospital District	Bosque County Hospital District	Private	IGT	\$ 2,066.57	\$ 4,716.04
6	450-19-0008-00162	Brazosport Regional Health System	Harris County Hospital District dba LPFF	Private	IGT	\$ 27,774.92	\$ 63,384.12
6	450-19-0007-00063	BT Garland JV LLP	Dallas County Hosp Dist dba Parkland Health & Human LPFF	Private	IGT	\$ 27,095.35	\$ 61,833.30
6	450-19-0007-00139	Carthage Hospital LLC	Smith County LPFF	Private	IGT	\$ 11,497.01	\$ 26,236.89
6	450-19-0007-00123	Cedar Park Health System LP dba Cedar Park Reg Med	Williamson County (LPFF)	Private	IGT	\$ 31,590.97	\$ 72,092.58
6	450-19-0008-00120	CHCA Bayshore LP dba Bayshore Medical Center	Harris County Hospital District dba LPFF	Private	IGT	\$ 148,013.64	\$ 337,776.45
6	450-19-0008-00123	CHCA Clear Lake LP dba Clear Lake Regional Medical	Harris County Hospital District dba LPFF	Private	IGT	\$ 266,588.72	\$ 608,372.25
6	450-19-0008-00122	CHCA West Houston LP dba West Houston Medical Cent	Harris County Hospital District dba LPFF	Private	IGT	\$ 96,287.02	\$ 219,733.04
6	450-19-0007-00071	Children's Medical Center of Dallas	Dallas County Hosp Dist dba Parkland Health & Human LPFF	Private	IGT	\$ 5,700,722.99	\$ 13,009,408.92
6	450-19-0007-00076	Children's Medical Center of Dallas (Plano)	Dallas County Hosp Dist dba Parkland Health & Human LPFF	Private	IGT	\$ 388,836.69	\$ 887,349.82
6	450-19-0008-00181	Christus Health Southeast TX dba Christus St Eliza	City of Beaumont LPFF	Private	IGT	\$ 205,392.12	\$ 468,717.75
6	450-19-0007-00134	Christus Hopkins Health Alliance	Smith County LPFF	Private	IGT	\$ 25,098.61	\$ 57,276.61
6	450-21-0001-00000	Christus Santa Rosa Health Care Corporation	Hays County Tax Assessor LPFF	Private	IGT	\$ 90,993.81	\$ 207,653.60
6	529-08-0236-00016	Christus Santa Rosa Hospital	Bexar County Hospital District (Univ Hlth Sys)	Private	IGT	\$ 244,106.18	\$ 557,065.68
6	600-12-0000-00185	Christus Santa Rosa Hospital	Bexar County Hospital	Private	IGT	\$ 1,018,983.83	\$ 2,325,385.27
6	600-12-0000-00111	Christus Spohn Hospital Kieberg	Nueces County Hospital District	Private	IGT	\$ 15,956.36	\$ 36,413.41
6	450-19-0008-00098	Clarity Child Guidance Center	Bexar County Hospital District LPFF	Private	IGT	\$ 60,614.80	\$ 138,326.79
6	450-19-0007-00054	Columbia Hosp at Med City Dallas Subsid dba Medica	Dallas County Hosp Dist dba Parkland Health & Human LPFF	Private	IGT	\$ 1,344,662.73	\$ 3,068,605.04
6	450-19-0007-00061	Columbia Medical Center of Denton dba Denton Regio	Dallas County Hosp Dist dba Parkland Health & Human LPFF	Private	IGT	\$ 104,806.94	\$ 239,176.03
6	450-19-0007-00057	Columbia Medical Center of Las Colinas Inc dba Las	Dallas County Hosp Dist dba Parkland Health & Human LPFF	Private	IGT	\$ 51,353.22	\$ 117,191.28
6	450-19-0007-00081	Columbia Medical Center of Plano Subsidiary LP dba	Dallas County Hosp Dist dba Parkland Health & Human LPFF	Private	IGT	\$ 319,493.64	\$ 729,104.61
6	450-19-0007-00059	Columbia Medical Ctr of Lewisville Subsidiary LP d	Dallas County Hosp Dist dba Parkland Health & Human LPFF	Private	IGT	\$ 171,667.24	\$ 391,755.45
6	450-19-0007-00040	Columbia North Hills Hospital Subsidiary LP dba No	Tarrant County Hospital Dist JPS (LPFF)	Private	IGT	\$ 70,137.27	\$ 160,057.67
6	450-19-0007-00041	Columbia Plaza Medical Center of Fort Worth LP dba	Tarrant County Hospital Dist JPS (LPFF)	Private	IGT	\$ 234,877.11	\$ 536,004.35
6	450-19-0008-00013	Columbia Rio Grande Healthcare dba Rio Grande Regi	Hidalgo County dba Hidalgo Cnty HCFD LPFF	Private	IGT	\$ 171,683.98	\$ 391,793.66
6	450-19-0007-000207	Columbia Valley Regional Medical Center	Cameron County Health Care Funding District (LPFF)	Private	IGT	\$ 146,914.67	\$ 335,268.52
6	600-12-0000-00215	Columbus Community Hospital	Gonzales County Hospital District	Private	IGT	\$ 3,568.88	\$ 8,144.40
6	600-12-0000-00084	Comanche County Medical Center Company	Comanche County Consolidated Hospital District	Private	IGT	\$ 921.46	\$ 2,102.83
6	450-19-0008-00124	Conroe Regional Medical Center	Harris County Hospital District dba LPFF	Private	IGT	\$ 81,233.49	\$ 185,379.94
6	450-19-0007-00049	Cook-Fort Worth Children's Medical Center	Tarrant County Hospital Dist JPS (LPFF)	Private	IGT	\$ 13,152,757.61	\$ 30,015,421.29
6	450-20-0011-00003	Corpus Christi Medical Center	Nueces County Hospital District LPFF	Private	IGT	\$ 151,685.75	\$ 346,156.43
6	450-19-0007-000200	Covenant Health System dba Covenant Medical Center	Lubbock County Hospital District LPFF	Private	IGT	\$ 579,341.07	\$ 1,322,092.81
6	450-20-0008-00001	Covenant Hospital Plainview	Lubbock County Hospital District LPFF	Private	IGT	\$ 51,895.92	\$ 118,429.75
6	600-18-0012-00000	Culberson Hospital	Culberson County Hospital District	Private	IGT	\$ 574.29	\$ 1,310.57
6	450-19-0007-00070	Dallas Medical Center	Dallas County Hosp Dist dba Parkland Health & Human LPFF	Private	IGT	\$ 34,799.78	\$ 79,415.29
6	450-19-0008-00068	Daughters of Charity Health Services of Austin dba	Travis County Healthcare District dba LPFF	Private	IGT	\$ 34,336.61	\$ 78,358.30
6	450-19-0008-00020	DeTar Hospital	Gregg County LPFF	Private	IGT	\$ 113,080.07	\$ 258,055.84
6	450-19-0007-000203	Doctor's Hospital at Renaissance	Hidalgo County dba Hidalgo Cnty HCFD LPFF	Private	IGT	\$ 397,260.87	\$ 906,574.33
6	600-12-0000-00081	El Campo Memorial Hospital	West Wharton County Hospital District	Private	IGT	\$ 2,500.00	\$ 5,705.16
6	450-19-0008-00178	El Paso Children's Hospital Corporation	El Paso County Hospital District LPFF	Private	IGT	\$ 75,094.38	\$ 171,370.10
6	450-19-0008-00173	El Paso Healthcare System Ltd dba Las Palmas Med C	El Paso County Hospital District LPFF	Private	IGT	\$ 754,844.08	\$ 1,722,601.73
6	450-21-0004-00000	Essent PRMC LP dba Paris Regional Medical Center	Ellis County LPFF	Private	IGT	\$ 65,159.75	\$ 148,698.65
6	600-12-0000-00135	Frio Regional Hospital	Frio Hospital District	Private	IGT	\$ 8,726.58	\$ 19,914.60

TEXAS HEALTH AND HUMAN SERVICES COMMISSION  
1115 WAIVER QUARTERLY PAYMENTS AND STATE MATCHING SHARE SUMMARY  
STC 37(b)  
FY 2021 Q3  
Uncompensated Care (UC) Program - Hospitals/Physicians Payment Detail

DY	Affiliation Number	Provider	Govt Affiliation	Federal Category of Service	Source of State Match	IGT Total Pd 3Q21	Payment Total Pd 3Q21
6	450-19-0008-00015	Good Shepherd Medical Center	Gregg County LPPF	Private	IGT	\$ 159,921.98	\$ 364,952.02
6	529-08-0236-00137	GPCH LLC dba Golden Plains Community Hospital	Hutchinson County Hospital District	Private	IGT	\$ 7,495.96	\$ 17,106.25
6	450-19-0008-00056	Grimes St Joseph Health Center	Brazos County dba Brazos County LPPF	Private	IGT	\$ 12,950.31	\$ 29,553.42
6	450-19-0007-00206	Harlingen Medical Center	Cameron County Health Care Funding District (LPPF)	Private	IGT	\$ 492,689.04	\$ 1,124,347.41
6	450-19-0007-00045	Harris Methodist Fort Worth Hospital	Tarrant County Hospital Dist JPS (LPPF)	Private	IGT	\$ 583,081.82	\$ 1,330,629.44
6	450-19-0007-00140	Henderson Hospital LLC	Smith County LPPF	Private	IGT	\$ 38,397.83	\$ 87,626.27
6	450-19-0012-00000	Hendrick Medical Center	Taylor County LPPF	Private	IGT	\$ 175,238.65	\$ 399,905.64
6	450-19-0008-00000	HH Killeen Health System LLC dba Seton Med Ctr Har	Bell County LPPF Fund	Private	IGT	\$ 42,841.37	\$ 97,766.70
6	600-12-0000-00232	Hill Country Memorial Hospital	Fredericksburg Hospital Authority	Private	IGT	\$ 22,055.52	\$ 50,332.08
6	450-19-0008-00021	Hill Regional Hospital	Gregg County LPPF	Private	IGT	\$ 17,580.11	\$ 40,118.92
6	450-19-0007-00007	Hillcrest Baptist Medical Center	McLennan County (LPPF)	Private	IGT	\$ 93,101.10	\$ 212,462.57
6	450-19-0008-00169	Houston Methodist St. John Hospital	Harris County Hospital District dba LPPF	Private	IGT	\$ 56,609.14	\$ 129,185.62
6	450-19-0008-00128	Houston Northwest Operations Co LLC dba Houston NW	Harris County Hospital District dba LPPF	Private	IGT	\$ 161,657.01	\$ 368,911.47
6	450-19-0008-00127	Houston-PPH LLC dba Park Plaza Hospital	Harris County Hospital District dba LPPF	Private	IGT	\$ 7,917.84	\$ 18,069.01
6	450-19-0007-00141	Jacksonville Hospital LLC	Smith County LPPF	Private	IGT	\$ 26,616.74	\$ 60,741.08
6	450-19-0008-00012	Knapp Medical Center	Hidalgo County dba Hidalgo Cnty HCDF LPPF	Private	IGT	\$ 136,961.04	\$ 312,553.72
6	450-19-0008-00126	KPH Consolidation Inc dba Kingwood Medical Center	Harris County Hospital District dba LPPF	Private	IGT	\$ 204,084.60	\$ 465,733.91
6	450-19-0007-00055	Lake Pointe Operating Company LLC dba Lake Pointe	Dallas County Hosp Dist dba Parkland Health & Human LPPF	Private	IGT	\$ 85,562.06	\$ 195,258.01
6	450-19-0007-00003	Laredo Reg Med Ctr dba Doctor's Hospital of Laredo	Webb County dba Webb County LPPF	Private	IGT	\$ 101,819.95	\$ 232,359.53
6	450-19-0007-00004	Laredo Texas Hospital Company LP dba Laredo Med Ct	Webb County dba Webb County LPPF	Private	IGT	\$ 253,138.32	\$ 577,677.58
6	450-19-0008-00014	Longview Medical Center LP	Gregg County LPPF	Private	IGT	\$ 84,506.46	\$ 192,849.06
6	450-19-0007-00202	Lubbock Heritage Hospital dba Grace Medical Center	Lubbock County Hospital District LPPF	Private	IGT	\$ 10,794.83	\$ 24,634.48
6	600-12-0000-00106	McCulloch County Hospital District dba Heart of Tx	McCulloch County Hospital District	Private	IGT	\$ 4,818.01	\$ 10,995.00
6	450-19-0007-00039	Medical Center of Arlington	Tarrant County Hospital Dist JPS (LPPF)	Private	IGT	\$ 395,144.74	\$ 901,745.18
6	450-19-0008-00136	Memorial Hermann Hospital Katy	Harris County Hospital District dba LPPF	Private	IGT	\$ 125,075.97	\$ 285,431.24
6	450-19-0008-00131	Memorial Hermann Hospital Memorial City	Harris County Hospital District dba LPPF	Private	IGT	\$ 468,112.92	\$ 1,068,263.17
6	450-19-0008-00132	Memorial Hermann Hospital Southwest dba Memorial H	Harris County Hospital District dba LPPF	Private	IGT	\$ 1,910,644.99	\$ 4,360,212.21
6	450-19-0008-00133	Memorial Hermann Hospital Sugar Land	Harris County Hospital District dba LPPF	Private	IGT	\$ 149,279.76	\$ 340,665.81
6	450-19-0008-00134	Memorial Hermann Hospital System (The Woodlands)	Harris County Hospital District dba LPPF	Private	IGT	\$ 1,117,879.98	\$ 2,551,072.52
6	450-19-0008-00135	Memorial Hermann Hospital System dba Memorial Herm	Harris County Hospital District dba LPPF	Private	IGT	\$ 226,594.27	\$ 517,102.40
6	450-19-0007-00090	Memorial Medical Center Lufkin	Angelina County dba Angelina County LPPF	Private	IGT	\$ 48,756.24	\$ 111,264.81
6	450-19-0007-00169	Memorial Medical Center San Augustine dba CHI St L	Angelina County dba Angelina County LPPF	Private	IGT	\$ 1,914.04	\$ 4,367.96
6	450-19-0007-00201	Methodist Children's dba Covenant Children's Hospi	Lubbock County Hospital District LPPF	Private	IGT	\$ 642,232.90	\$ 1,465,615.92
6	600-18-0011-00000	Methodist Healthcare System of San Antonio dba Met	University Health System (Bexar County)	Private	IGT	\$ 21,247.61	\$ 48,488.38
6	529-10-0065-00096	Methodist Hlthcare Sys of SA dba Methodist Stone Oak Hosp	Bexar County Hospital District (Univ Hlth Sys)	Private	IGT	\$ 100,444.54	\$ 229,220.76
6	529-08-0236-00077	Methodist Hlthcare Sys of SA Methodist Ambulatory Surgical Hosp	Bexar County Hospital District (Univ Hlth Sys)	Private	IGT	\$ 11,102.80	\$ 25,337.28
6	529-08-0236-00078	Methodist Hlthcare Sys of SA Southwest Texas Methodist Hosp	Bexar County Hospital District (Univ Hlth Sys)	Private	IGT	\$ 1,160,727.48	\$ 2,648,853.21
6	600-12-0000-00083	Methodist Hosp Levelland dba Covenant Hosp Levelland	Hockley County	Private	IGT	\$ 36,865.46	\$ 84,129.30
6	450-19-0007-00072	Methodist Hosp of Dallas dba Methodist Richardson	Dallas County Hosp Dist dba Parkland Health & Human LPPF	Private	IGT	\$ 79,557.54	\$ 181,555.32
6	450-19-0007-00064	Methodist Hospitals of Dallas dba Methodist Charit	Dallas County Hosp Dist dba Parkland Health & Human LPPF	Private	IGT	\$ 256,043.69	\$ 584,307.82
6	450-19-0007-00065	Methodist Hospitals of Dallas dba Methodist Dailas	Dallas County Hosp Dist dba Parkland Health & Human LPPF	Private	IGT	\$ 295,603.05	\$ 674,584.78
6	450-19-0007-00046	Methodist Hospitals of Dallas Methodist Mansfield	Tarrant County Hospital Dist JPS (LPPF)	Private	IGT	\$ 78,683.15	\$ 179,559.90
6	450-19-0008-00186	Methodist Sugar Land	Harris County Hospital District dba LPPF	Private	IGT	\$ 92,730.58	\$ 211,617.02

TEXAS HEALTH AND HUMAN SERVICES COMMISSION  
1115 WAIVER QUARTERLY PAYMENTS AND STATE MATCHING SHARE SUMMARY  
STC 37(b)  
FY 2021 Q3  
Uncompensated Care (UC) Program - Hospitals/Physicians Payment Detail

DY	Affiliation Number	Provider	Govt Affiliation	Federal Category of Service	Source of State Match	IGT Total Pd 3Q21	Payment Total Pd 3Q21
6	450-19-0008-00139	Methodist West Houston Hospital	Harris County Hospital District dba LPFF	Private	IGT	\$ 69,922.49	\$ 159,567.52
6	450-19-0008-00140	Methodist Willowbrook	Harris County Hospital District dba LPFF	Private	IGT	\$ 160,056.77	\$ 365,259.63
6	450-19-0008-00011	Metroplex Adventist Hospital Inc dba Adventhealth	Bell County LPFF Fund	Private	IGT	\$ 63,989.46	\$ 146,027.98
6	450-19-0007-00204	Mission Hospital Inc	Hidalgo County dba Hidalgo Cnty HCFF LPFF	Private	IGT	\$ 44,019.78	\$ 100,455.91
6	450-19-0007-00133	Mother Frances Hospital	Smith County LPFF	Private	IGT	\$ 177,348.11	\$ 404,719.56
6	450-19-0007-00132	Mother Frances Hospital Jacksonville	Smith County LPFF	Private	IGT	\$ 11,336.20	\$ 25,869.92
6	450-19-0007-00135	Mother Frances Hospital Winnboro dba Christus Mot	Smith County LPFF	Private	IGT	\$ 6,009.22	\$ 13,713.41
6	450-19-0008-00121	North Houston-TRMC LLC dba Tomball Regional Medica	Harris County Hospital District dba LPFF	Private	IGT	\$ 175,733.76	\$ 401,035.50
6	450-19-0007-00034	North Texas MCA LLC dba Medical Center of Alliance	Tarrant County Hospital Dist JPS (LPFF)	Private	IGT	\$ 32,531.94	\$ 74,239.94
6	450-19-0007-00077	OCH Holdings	Dallas County Hosp Dist dba Parkland Health & Human LPFF	Private	IGT	\$ 163,418.07	\$ 372,930.33
6	529-08-0236-00091	Odessa Regional Medical Center	Midland County Hospital District	Private	IGT	\$ 159,843.52	\$ 364,772.98
6	529-08-0236-00096	Parmer County Community Hospital	Parmer County Hospital District	Private	IGT	\$ 1,558.29	\$ 3,556.11
6	450-19-0007-00060	Pipeline East Dallas LLC dba City Hospital White R	Dallas County Hosp Dist dba Parkland Health & Human LPFF	Private	IGT	\$ 38,596.91	\$ 88,080.58
6	450-19-0007-00142	Pittsburg Hospital LLC	Smith County LPFF	Private	IGT	\$ 9,969.49	\$ 22,751.00
6	450-19-0008-00142	PMC Hospital LLC dba St Luke's Patients Medical Ce	Harris County Hospital District dba LPFF	Private	IGT	\$ 17,597.57	\$ 40,158.76
6	529-10-0065-00028	Preferred Hosp Leasing Eldorado, Inc. dba Schleich	Schleicher County Medical Center	Private	IGT	\$ 366.50	\$ 836.37
6	450-19-0007-00053	Presbyterian Hospital of Dallas	Dallas County Hosp Dist dba Parkland Health & Human LPFF	Private	IGT	\$ 360,736.52	\$ 823,223.46
6	600-12-0000-00002	PRHC-Ennis, L.P. dba Ennis Regional Medical Center	Ellis County	Private	IGT	\$ 65,349.76	\$ 149,132.26
6	600-19-0008-00006	Prime Healthcare Services - Pampa, LLC dba Pampa R	Hansford County Hospital District	Private	IGT	\$ 45,959.94	\$ 104,883.47
6	450-19-0007-00068	Prime Healthcare Services Mesquite LLC dba Dallas	Dallas County Hosp Dist dba Parkland Health & Human LPFF	Private	IGT	\$ 15,962.55	\$ 36,427.54
6	450-19-0007-00008	Providence Hlth Svcs of Waco dba St. Catherine Ctr	McLennan County (LPFF)	Private	IGT	\$ 84,580.75	\$ 193,018.60
6	450-19-0007-00143	Quitman Hospital LLC	Smith County LPFF	Private	IGT	\$ 5,890.60	\$ 13,442.72
6	600-16-0006-00000	Resolute Hospital Company LLC	University Health System (Bexar County)	Private	IGT	\$ 3,965.23	\$ 9,048.90
6	529-10-0065-00092	Rice Medical Center	Rice Hospital District	Private	IGT	\$ 664.11	\$ 1,515.54
6	450-19-0007-00093	San Angelo Community Medical Center	Tom Green County (LPFF)	Private	IGT	\$ 38,448.26	\$ 87,741.35
6	450-19-0008-00141	San Jacinto Methodist Hospital	Harris County Hospital District dba LPFF	Private	IGT	\$ 100,138.89	\$ 228,523.25
6	450-20-0012-00000	Sana Healthcare Carrollton LLC dba Carrollton Reg	Tarrant County Hospital Dist JPS (LPFF)	Private	IGT	\$ 54,481.52	\$ 124,330.25
6	450-19-0007-00122	Scott & White Healthcare - Round Rock	Williamson County (LPFF)	Private	IGT	\$ 42,687.41	\$ 97,415.36
6	450-19-0008-00042	Scott & White Hospital - College Station	Brazos County dba Brazos County LPFF	Private	IGT	\$ 30,798.05	\$ 70,283.08
6	450-19-0008-00007	Scott & White Hospital Brenham	Bell County LPFF Fund	Private	IGT	\$ 24,959.97	\$ 56,960.22
6	450-19-0008-00188	Scott & White Memorial Hospital c/o State Comp Dep	Bell County LPFF Fund	Private	IGT	\$ 319,198.13	\$ 728,430.23
6	450-19-0008-00180	Seton Family of Hospitals dba Dell Childrens Med C	Travis County Healthcare District dba LPFF	Private	IGT	\$ 2,020,219.09	\$ 4,610,267.21
6	450-19-0008-00064	Seton Family of Hospitals dba Seton Medical Center	Travis County Healthcare District dba LPFF	Private	IGT	\$ 197,029.16	\$ 449,632.95
6	450-19-0008-00065	Seton Family of Hospitals dba Seton Northwest	Travis County Healthcare District dba LPFF	Private	IGT	\$ 49,244.67	\$ 112,379.44
6	450-19-0007-00121	Seton Healthcare	Williamson County (LPFF)	Private	IGT	\$ 40,897.88	\$ 93,331.54
6	450-19-0008-00168	Seton Healthcare dba Seton Medical Center Hays	Hays County Tax Assessor LPFF	Private	IGT	\$ 139,293.64	\$ 317,876.85
6	450-19-0007-00021	Seton Healthcare dba Seton Smithville Regional Hos	McLennan County (LPFF)	Private	IGT	\$ 3,291.32	\$ 7,511.00
6	450-19-0008-00066	Seton Shoal Creek Hospital	Travis County Healthcare District dba LPFF	Private	IGT	\$ 370,823.42	\$ 846,242.40
6	450-19-0007-00035	Sherman/Grayson Hospital LLC dba Wilson N Jones Re	Grayson County Cty Health Dep/LPFF	Private	IGT	\$ 39,815.32	\$ 90,861.07
6	600-12-0000-00077	Sid Peterson Memorial Hospital dba Peterson Reg Med Ctr	Fredericksburg Hospital Authority	Private	IGT	\$ 34,619.53	\$ 79,003.94
6	450-19-0008-00176	Sierra Providence East Medical Center	El Paso County Hospital LPFF	Private	IGT	\$ 111,101.85	\$ 253,541.42
6	600-13-0000-00126	SJ Medical Center LLC (prev St Joseph Medical Center, prev Christu	Midland County Hospital District	Private	IGT	\$ 75,439.06	\$ 172,156.68
6	600-13-0000-00102	Southwest General Hospital	Midland County Hospital District	Private	IGT	\$ 152,844.88	\$ 348,801.64

TEXAS HEALTH AND HUMAN SERVICES COMMISSION  
1115 WAIVER QUARTERLY PAYMENTS AND STATE MATCHING SHARE SUMMARY  
STC 37(b)  
FY 2021 Q3  
Uncompensated Care (UC) Program - Hospitals/Physicians Payment Detail

DY	Affiliation Number	Provider	Govt Affiliation	Federal Category of Service	Source of State Match	IGT Total Pd 3Q21	Payment Total Pd 3Q21
6	450-19-0008-00070	St Davids Hlthcare Partnership dba North Austin Me	Travis County Healthcare District dba LPPF	Private	IGT	\$ 406,284.50	\$ 927,166.82
6	450-19-0007-00170	St Davids Hlthcare Partnership dba Round Rock Med	Williamson County (LPPF)	Private	IGT	\$ 54,622.94	\$ 124,652.99
6	450-19-0008-00071	St Davids Hlthcare Partnership dba South Austin Me	Travis County Healthcare District dba LPPF	Private	IGT	\$ 119,462.01	\$ 272,619.83
6	450-19-0008-00072	St Davids Hlthcare Partnership dba St Davids Med C	Travis County Healthcare District dba LPPF	Private	IGT	\$ 252,502.00	\$ 576,225.46
6	450-19-0008-00057	St Joseph Regional Health Center	Brazos County dba Brazos County LPPF	Private	IGT	\$ 145,233.41	\$ 331,431.79
6	450-19-0008-00031	St Joseph Regional Health Center dba CHI St Joseph	Brazos County dba Brazos County LPPF	Private	IGT	\$ 48,025.17	\$ 109,596.46
6	450-19-0008-00143	St Luke's Sugarland Hospital	Harris County Hospital District dba LPPF	Private	IGT	\$ 32,430.28	\$ 74,007.94
6	450-19-0008-00184	St Marks Medical Center	City of Beaumont LPPF	Private	IGT	\$ 14,183.14	\$ 32,366.82
6	450-19-0008-00144	St. Luke's Community Health Svcs (The Woodlands)	Harris County Hospital District dba LPPF	Private	IGT	\$ 154,223.94	\$ 351,948.74
6	450-19-0008-00163	St. Luke's Episcopal Hospital	Harris County Hospital District dba LPPF	Private	IGT	\$ 987,741.67	\$ 2,254,088.70
6	450-19-0008-00187	St. Lukes Hospital at the Vintage	Harris County Hospital District dba LPPF	Private	IGT	\$ 82,052.75	\$ 187,249.54
6	450-19-0008-00146	St. Luke's Lakeside Hospital	Harris County Hospital District dba LPPF	Private	IGT	\$ 6,712.97	\$ 15,319.42
6	600-19-0008-00007	Steward Texas Hospital Holdings LLC	Midland County Hospital District	Private	IGT	\$ 23,184.52	\$ 52,908.53
6	450-19-0007-00075	Tenet Frisco Ltd dba Centennial Medical Center	Dallas County Hosp Dist dba Parkland Health & Human LPPF	Private	IGT	\$ 8,870.82	\$ 20,243.77
6	450-19-0008-00175	Tenet Hospitals Limited dba Sierra Medical Center	El Paso County Hospital District LPPF	Private	IGT	\$ 88,179.38	\$ 201,230.89
6	450-19-0008-00174	Tenet Hospitals Limited dba Sierra Providence Heal	El Paso County Hospital District LPPF	Private	IGT	\$ 156,320.96	\$ 356,734.28
6	450-19-0008-00137	Texas Children's Hospital	Harris County Hospital District dba LPPF	Private	IGT	\$ 13,182,528.29	\$ 30,083,359.85
6	450-19-0007-00036	Texas Health Arlington Memorial Hospital	Tarrant County Hospital Dist JPS (LPPF)	Private	IGT	\$ 238,176.33	\$ 543,533.39
6	450-19-0007-00056	Texas Health Denton	Dallas County Hosp Dist dba Parkland Health & Human LPPF	Private	IGT	\$ 150,090.35	\$ 342,515.63
6	450-19-0007-00042	Texas Health Harris Methodist HEB	Tarrant County Hospital Dist JPS (LPPF)	Private	IGT	\$ 139,051.91	\$ 317,325.22
6	450-19-0007-00052	Texas Health Harris Methodist Hospital Alliance	Tarrant County Hospital Dist JPS (LPPF)	Private	IGT	\$ 58,284.25	\$ 133,008.33
6	450-19-0007-00043	Texas Health Harris Methodist Hospital Azle	Tarrant County Hospital Dist JPS (LPPF)	Private	IGT	\$ 19,026.09	\$ 43,418.74
6	450-19-0007-00048	Texas Health Harris Methodist Hospital Cleburne	Tarrant County Hospital Dist JPS (LPPF)	Private	IGT	\$ 52,698.39	\$ 120,261.04
6	450-19-0007-00051	Texas Health Huguley INC dba Huguley Memorial Me	Tarrant County Hospital Dist JPS (LPPF)	Private	IGT	\$ 138,555.77	\$ 316,192.99
6	450-19-0007-00078	Texas Health Presbyterian Hospital Allen	Dallas County Hosp Dist dba Parkland Health & Human LPPF	Private	IGT	\$ 42,706.77	\$ 97,459.54
6	450-19-0007-00058	Texas Health Presbyterian Hospital Kaufman	Dallas County Hosp Dist dba Parkland Health & Human LPPF	Private	IGT	\$ 23,906.05	\$ 54,555.11
6	450-19-0007-00079	Texas Health Presbyterian Hospital Plano	Dallas County Hosp Dist dba Parkland Health & Human LPPF	Private	IGT	\$ 348,181.16	\$ 794,571.34
6	450-19-0007-00073	Texas Regional Medical Center LLC dba Baylor Scott	Dallas County Hosp Dist dba Parkland Health & Human LPPF	Private	IGT	\$ 62,533.17	\$ 142,704.63
6	450-19-0007-00095	Texas Scottish Rite Hospital for Crippled Children	Dallas County Hosp Dist dba Parkland Health & Human LPPF	Private	IGT	\$ 1,421,081.96	\$ 3,242,998.54
6	450-19-0007-00086	The Heart Hospital Baylor Denton	Dallas County Hosp Dist dba Parkland Health & Human LPPF	Private	IGT	\$ 471.38	\$ 1,075.72
6	450-19-0007-00085	The Heart Hospital Baylor Plano	Dallas County Hosp Dist dba Parkland Health & Human LPPF	Private	IGT	\$ 5,711.19	\$ 13,033.30
6	600-13-0000-00106	The Medical Center of Southeast Texas LP	Midland County Hospital District	Private	IGT	\$ 87,039.63	\$ 198,629.91
6	450-19-0008-00138	The Methodist Hospital	Harris County Hospital District dba LPPF	Private	IGT	\$ 257,190.58	\$ 586,925.10
6	450-19-0007-00137	Tyler Regional Hospital LLC	Smith County LPPF	Private	IGT	\$ 116,770.00	\$ 266,476.49
6	600-12-0000-00240	UHS AT Amarillo Inc dba Northwest Texas Hospital	Amarillo Hospital District	Private	IGT	\$ 192,328.53	\$ 438,905.82
6	450-19-0007-00083	UHS of Texoma Inc dba Texoma Medical Center	Grayson County Cty Health Dept/LPPF	Private	IGT	\$ 104,925.16	\$ 239,445.82
6	450-19-0011-00000	United Regional Health Care System	Wichita County LPPF	Private	IGT	\$ 187,236.16	\$ 427,284.71
6	450-19-0007-00209	Valley Baptist Medical Center (Harlingen)	Cameron County Health Care Funding District (LPPF)	Private	IGT	\$ 103,766.85	\$ 236,802.48
6	450-19-0007-00208	Valley Baptist Medical Center- Brownsville	Cameron County Health Care Funding District (LPPF)	Private	IGT	\$ 52,569.79	\$ 119,967.57
6	600-13-0000-00101	Wadley Regional Medical Center	Midland County Hospital District	Private	IGT	\$ 37,952.90	\$ 86,610.90
6	529-08-0236-00113	Walker Co Hospital Corporation dba Huntsville Mem Hosp	Walker County Hospital District	Private	IGT	\$ 24,072.00	\$ 54,933.82
6	450-20-0009-00001	Weatherford Health Services LLC	Gregg County LPPF	Private	IGT	\$ 28,202.32	\$ 64,359.47
6	529-10-0065-00077	Winnie Community Hospital	Winnie-Stowell Hospital District	Private	IGT	\$ 1,618.15	\$ 3,692.71



TEXAS HEALTH AND HUMAN SERVICES COMMISSION  
1115 WAIVER QUARTERLY PAYMENTS AND STATE MATCHING SHARE SUMMARY  
STC 37(b)  
FY 2021 Q3  
Uncompensated Care (UC) Program - Hospitals/Physicians Payment Detail

DY	Affiliation Number	Provider	Govt Affiliation	Federal Category of Service	Source of State Match	IGT Total Pd 3Q21	Payment Total Pd 3Q21
6	700-12-0000-00002	Dallas County Hospital District dba Parkland Hlth & Hosp Sys	Dallas County Hospital District dba Parkland Health and Hospital	Public NS	IGT	\$ 297,528.58	\$ 678,978.97
6	700-12-0000-00004	El Paso Co Hosp Dist - University Medical Center of El Paso	El Paso County Hospital District dba University Medical Center of	Public NS	IGT	\$ 89,536.81	\$ 204,328.64
6	100-13-0000-00131	Harris County Hospital District	Harris County Hospital District	Public NS	IGT	\$ 226,496.79	\$ 516,879.94
6	450-19-0008-00061	Seton Family of Hospitals Dell Seton Med Ctr @UT	Travis County LPPE	Public NS	IGT	\$ 100,294.99	\$ 228,879.49
6	700-12-0000-00007	Tarrant County Hospital District dba JPS Health Network	Tarrant County Hospital District (John Peter Smith Hosp)	Public NS	IGT	\$ 122,438.71	\$ 279,412.84
6	700-12-0000-00015	University Health System (Bexar County Hospital District)	Bexar County Hospital District (Univ Hlth Sys)	Public NS	IGT	\$ 462,109.51	\$ 1,054,563.00
6	700-12-0000-00003	Ector County Hospital District dba Medical Center Hospital	Ector County Hospital District	Public NS	IGT	\$ 199,681.50	\$ 455,685.76
6	100-18-0006-00000	Fairfield Hospital District dba Freestone Medical	Fairfield Hospital District	Public NS	IGT	\$ 6,411.00	\$ 14,630.30
6	700-12-0000-00008	Lubbock County Hospital District dba University Medical Center	Lubbock County Hospital District	Public NS	IGT	\$ 679,269.56	\$ 1,550,135.91
6	700-12-0000-00009	Midland County Hospital District dba Midland Memorial Hospital	Midland County Hospital District	Public NS	IGT	\$ 87,289.45	\$ 199,200.02
6	100-13-0000-00129	Oak Bend Medical Center	Oak Bend Medical Center	Public NS	IGT	\$ 50,996.63	\$ 116,377.52
6	100-13-0000-00116	Wilbarger General Hospital	Wilbarger County Hospital District	Public NS	IGT	\$ 4,423.00	\$ 10,093.56
6	100-17-0001-00000	Anson General Hospital	Anson General Hospital	Public NS	IGT	\$ 819.33	\$ 1,869.76
6	800-12-0000-00003	Ballinger Memorial Hospital	Ballinger Memorial Hospital District	Public NS	IGT	\$ 390.54	\$ 891.23
6	800-12-0000-00004	Bayside Community Hospital	Chambers County Hospital District	Public NS	IGT	\$ 1,238.75	\$ 2,826.90
6	600-12-0000-00127	Belleville St. Joseph Health Center	Belleville Hospital District	Public NS	IGT	\$ 1,498.35	\$ 3,419.33
6	800-12-0000-00007	Childress Regional Medical Center	Childress County Hospital District dba Childress Regional Medical	Public NS	IGT	\$ 10,956.63	\$ 25,003.72
6	800-12-0000-00010	Clay County Memorial Hospital	Clay County Hospital District	Public NS	IGT	\$ 1,192.84	\$ 2,722.13
6	800-12-0000-00014	Concho County Hospital	Concho County Hospital District	Public NS	IGT	\$ 333.60	\$ 761.30
6	800-12-0000-00015	Coon Memorial Hospital dba Dallam-Hartley Counties Hosp District	Dallam-Hartley Counties Hospital District	Public NS	IGT	\$ 9,029.80	\$ 20,606.57
6	800-12-0000-00016	Coryell County Memorial Hospital Authority dba Coryell Memorial	Coryell County Memorial Hospital Authority	Public NS	IGT	\$ 2,174.31	\$ 4,961.91
6	800-12-0000-00009	County of Victoria dba Citizens Medical Center	Citizens Medical Center	Public NS	IGT	\$ 124,397.17	\$ 283,882.17
6	800-12-0000-00018	Crane County Hospital District dba Crane Memorial Hospital	Crane County Hospital District	Public NS	IGT	\$ 2,646.92	\$ 6,040.43
6	800-12-0000-00019	Cuero Community Hospital (Dewitt Med Dist)	Cuero Community Hospital	Public NS	IGT	\$ 12,474.73	\$ 28,468.12
6	800-12-0000-00021	D. M. Cogdell Memorial Hospital	DM Cogdell Memorial Hospital dba Scurry County	Public NS	IGT	\$ 3,322.87	\$ 7,583.00
6	800-12-0000-00109	Decatur Hospital Authority dba Wise Regional Health System	Decatur Hospital Authority dba Wise Regional Health System	Public NS	IGT	\$ 57,245.59	\$ 130,638.04
6	600-12-0000-00050	Dimmit County Memorial Hospital	Dimmit Regional Hospital District dba Dimmit Regional Hospital	Public NS	IGT	\$ 7,407.35	\$ 16,904.04
6	800-12-0000-00023	Eastland Memorial Hospital	Eastland Memorial Hospital District	Public NS	IGT	\$ 4,446.30	\$ 10,146.73
6	100-13-0000-00033	Electra Memorial Hospital	Electra Memorial Hospital (Electra Hospital District)	Public NS	IGT	\$ 1,504.99	\$ 3,434.48
6	800-12-0000-00034	Faith Community Hospital	Faith Community Hospital Auxiliary (Jack County Hospital District)	Public NS	IGT	\$ 1,131.79	\$ 2,582.82
6	100-15-0009-00001	Fannin County Hosp Auth dba TMC Bonham Hosp	Fannin County Hospital Authority dba TMC Bonham Hosp	Public NS	IGT	\$ 1,361.50	\$ 3,107.02
6	800-12-0000-00035	Fisher County Hospital	Fisher County Hospital District	Public NS	IGT	\$ 392.84	\$ 896.49
6	800-12-0000-00066	Gonzales County Hospital District	Gonzales County Hospital District	Public NS	IGT	\$ 5,994.23	\$ 13,679.21
6	100-16-0008-00000	Graham County Hospital District	Graham Hospital District	Public NS	IGT	\$ 3,654.43	\$ 8,339.64
6	800-12-0000-00040	Guadalupe Valley Hospital	Guadalupe County Hospital Board dba Guadalupe Regional Medi	Public NS	IGT	\$ 52,404.72	\$ 119,590.87
6	800-12-0000-00041	Hamilton County General Hospital Inc	Hamilton General Hospital	Public NS	IGT	\$ 2,461.00	\$ 5,616.16
6	800-12-0000-00043	Hansford Hospital	Hansford County Hospital District	Public NS	IGT	\$ 780.46	\$ 1,781.05
6	800-12-0000-00044	Hardeman County Memorial Hospital	Hardeman County Hospital District	Public NS	IGT	\$ 1,322.07	\$ 3,017.05
6	800-12-0000-00045	Haskell Memorial Hospital	Haskell County Hospital District	Public NS	IGT	\$ 363.48	\$ 829.48
6	800-12-0000-00048	Hereford Regional Medical Center	Deaf Smith County Hospital District	Public NS	IGT	\$ 11,096.60	\$ 25,323.14
6	800-12-0000-00085	Hunt Mem Hosp Dist dba Hunt Reg Med Ctr	Hunt Memorial Hospital District	Public NS	IGT	\$ 45,803.19	\$ 104,525.76
6	800-12-0000-00050	Iraan General Hospital (Pecos General)	Iraan General Hospital District	Public NS	IGT	\$ 212.00	\$ 483.80
6	800-12-0000-00051	Jackson County Hospital	Jackson County Hospital District	Public NS	IGT	\$ 5,931.44	\$ 13,535.92

TEXAS HEALTH AND HUMAN SERVICES COMMISSION  
 1115 WAIVER QUARTERLY PAYMENTS AND STATE MATCHING SHARE SUMMARY  
 STC 37(b)  
 FY 2021 Q3  
 Uncompensated Care (UC) Program - Hospitals/Physicians Payment Detail

DY	Affiliation Number	Provider	Govt Affiliation	Federal Category of Service	Source of State Match	IGT Total Pd 3Q21	Payment Total Pd 3Q21
6	800-12-0000-00052	Karnes County Hospital District dba Otto Kaiser Memorial Hospital	Karnes County Hospital District	Public NS	IGT	\$ 2,286.51	\$ 5,217.96
6	100-13-0000-00052	Knox County Hospital District dba Knox County Hosp	Knox County Hospital District	Public NS	IGT	\$ 333.33	\$ 760.68
6	800-12-0000-00054	Lamb Healthcare Center	Lamb County dba Lamb Healthcare Center	Public NS	IGT	\$ 6,765.00	\$ 15,438.16
6	800-12-0000-00055	Lavaca Medical Center	Lavaca Medical Center	Public NS	IGT	\$ 989.38	\$ 2,257.83
6	800-12-0000-00056	L M Hudspeth Memorial Hospital	L M Hudspeth Memorial Hospital	Public NS	IGT	\$ 1,576.51	\$ 3,597.69
6	600-12-0000-00236	Liberty-Dayton Regional Medical Center	Liberty County Hospital District #1	Public NS	IGT	\$ 1,729.24	\$ 3,946.23
6	800-12-0000-00057	Limestone Medical Center	South Limestone Hospital District	Public NS	IGT	\$ 2,165.23	\$ 4,941.18
6	800-12-0000-00059	Lockney Gen Hosp Dist (W.J. Mangold Mem Hosp)	Lockney County Hospital District (W J Mangold Mem Hosp)	Public NS	IGT	\$ 4,150.00	\$ 9,470.56
6	800-12-0000-00060	Lynn County Hospital District	Lynn County Hospital District	Public NS	IGT	\$ 368.50	\$ 840.94
6	800-12-0000-00061	Martin County Hospital District	Martin County Hospital District	Public NS	IGT	\$ 1,025.25	\$ 2,339.68
6	800-12-0000-00062	Matagorda County Hospital District dba Matagorda Regional Medi	Matagorda County Hospital District	Public NS	IGT	\$ 59,718.82	\$ 136,282.10
6	800-12-0000-00063	McCamery County Hospital District	McCamery Hospital & Convalescent Center	Public NS	IGT	\$ 198.22	\$ 452.34
6	800-12-0000-00064	Medical Arts Hospital	Dawson County Hospital District	Public NS	IGT	\$ 2,814.42	\$ 6,422.68
6	450-19-0007-00082	Medical Ctr of McKinney	Dallas County Hosp Dist dba Parkland Health & Human LPPF	Public NS	IGT	\$ 82,345.37	\$ 187,917.32
6	100-13-0000-00058	Medina County Hosp District dba Medina Regional Hosp	Medina County Hospital District dba Medina Regional Hospital	Public NS	IGT	\$ 1,970.85	\$ 4,497.60
6	800-12-0000-00108	Winkler County Memorial Hospital	Memorial Hospital of Winkler County	Public NS	IGT	\$ 848.24	\$ 1,935.74
6	800-12-0000-00067	Memorial Medical Center	Calhoun County dba Memorial Medical Center	Public NS	IGT	\$ 5,225.61	\$ 11,925.16
6	800-12-0000-00070	Mitchell County Hospital	Mitchell County Hospital District	Public NS	IGT	\$ 1,327.56	\$ 3,029.57
6	800-12-0000-00071	Moore County Hospital District	Moore County Hospital District	Public NS	IGT	\$ 28,966.59	\$ 66,103.58
6	800-12-0000-00072	Muenster Memorial Hospital	Muenster Memorial Hospital	Public NS	IGT	\$ 106.88	\$ 243.90
6	800-12-0000-00074	Nacogdoches Memorial Hospital	Nacogdoches County Hospital District	Public NS	IGT	\$ 22,137.73	\$ 50,519.69
6	800-12-0000-00075	Nocona General Hospital	Nocona General Hospital District	Public NS	IGT	\$ 1,241.07	\$ 2,832.20
6	800-12-0000-00076	North Runnels Hospital	North Runnels Hospital	Public NS	IGT	\$ 356.18	\$ 812.82
6	800-12-0000-00080	North Wheeler County Hospital District dba Parkview Hospital	North Wheeler County Hospital District DBA Parkview Hospital	Public NS	IGT	\$ 143.76	\$ 328.06
6	800-12-0000-00077	Ochiltree General Hospital	Ochiltree County Hospital District	Public NS	IGT	\$ 5,151.28	\$ 11,755.55
6	800-12-0000-00078	Olney Hamilton Hospital District dba Hamilton Hospital	Olney Hamilton Hospital District	Public NS	IGT	\$ 1,141.63	\$ 2,605.27
6	800-12-0000-00079	Palo Pinto County Hospital District dba Palo Pinto General Hospita	Palo Pinto County Hospital District	Public NS	IGT	\$ 6,779.63	\$ 15,471.54
6	800-12-0000-00081	Pecos County Memorial Hospital	Pecos County Memorial Hospital	Public NS	IGT	\$ 23,261.44	\$ 53,084.06
6	800-12-0000-00082	Permian Regional Medical Center	Permian Regional Medical Center	Public NS	IGT	\$ 6,939.97	\$ 15,837.45
6	800-12-0000-00083	Plains Memorial Hospital	Plains Memorial Hospital Disproportionate Share Act	Public NS	IGT	\$ 702.21	\$ 1,602.49
6	800-12-0000-00086	Rankin County Hospital	Rankin County Hospital District	Public NS	IGT	\$ 282.00	\$ 643.54
6	800-12-0000-00087	Reagan Hospital District dba Reagan Memorial Hospital	Reagan Memorial Hospital District	Public NS	IGT	\$ 175.24	\$ 399.90
6	800-12-0000-00088	Reeves County Hospital	Reeves County Hospital District	Public NS	IGT	\$ 4,525.30	\$ 10,327.02
6	800-12-0000-00089	Refugio County Memorial Hospital	Refugio County Memorial Hospital District	Public NS	IGT	\$ 2,548.86	\$ 5,816.66
6	800-12-0000-00090	Rolling Plains Memorial Hospital	Rolling Plains Memorial Hospital District	Public NS	IGT	\$ 5,660.42	\$ 12,917.43
6	800-12-0000-00092	Seminole HD of Gaines Co dba Memorial Hospital	Seminole Hospital District	Public NS	IGT	\$ 4,914.40	\$ 11,214.97
6	800-12-0000-00093	Seymour Hospital	Seymour Hospital (Baylor County HD)	Public NS	IGT	\$ 1,610.27	\$ 3,674.74
6	800-12-0000-00038	Somervell County Hospital District dba Glen Rose Med Ctr	Somervell County Hospital District	Public NS	IGT	\$ 1,710.99	\$ 3,904.58
6	700-12-0000-00011	Spohn Health System dba Spohn Memorial Hospital	Nueces County Hospital District	Public NS	IGT	\$ 170,135.06	\$ 388,258.92
6	800-12-0000-00097	Starr County Memorial Hospital	Starr County	Public NS	IGT	\$ 4,928.95	\$ 11,248.17
6	100-13-0000-00086	Stonewall Memorial Hospital	Stonewall Memorial Hospital	Public NS	IGT	\$ 620.58	\$ 1,416.20
6	700-12-0000-00012	Sweeny Community Hospital	Sweeny Memorial District	Public NS	IGT	\$ 1,412.56	\$ 3,223.54
6	600-12-0000-00210	Swisher County Memorial dba Swisher Memorial Hospital	Swisher Memorial Healthcare System (County Hospital District)	Public NS	IGT	\$ 1,004.45	\$ 2,292.22

TEXAS HEALTH AND HUMAN SERVICES COMMISSION  
1115 WAIVER QUARTERLY PAYMENTS AND STATE MATCHING SHARE SUMMARY  
STC 37(b)  
FY 2021 Q3

Uncompensated Care (UC) Program - Hospitals/Physicians Payment Detail

DY	Affiliation Number	Provider	Govt Affiliation	Federal Category of Service	Source of State Match	IGT Total Pd 3Q21	Payment Total Pd 3Q21
6	800-12-0000-00100	Terry Mem Hosp Dist dba Brownfield Reg Med Ctr	Terry Memorial Hospital District dba Brownfield Regional	Public NS	IGT	\$ 3,910.67	\$ 8,924.40
6	800-12-0000-00101	Titus Regional Medical Center	Titus County Memorial Hospital dba Titus Regional Medical	Public NS	IGT	\$ 54,984.53	\$ 125,478.16
6	800-12-0000-00103	Uvalde County Hospital Authority dba Uvalde Memorial Hospital	Uvalde County Hospital Authority	Public NS	IGT	\$ 84,689.35	\$ 193,266.43
6	800-12-0000-00104	Val Verde Regional Medical Center	Val Verde Regional Medical Center	Public NS	IGT	\$ 56,752.75	\$ 129,513.35
6	800-12-0000-00105	Ward Memorial Hospital	Ward Memorial Hospital	Public NS	IGT	\$ 3,467.69	\$ 7,913.49
6	800-12-0000-00107	Wilson Memorial Hospital - Floresville	Wilson County Memorial Hospital Floresville (Connally Memorial	Public NS	IGT	\$ 4,581.11	\$ 10,454.38
6	529-08-0236-00114	Yoakum Community Hospital	Yoakum Hospital District	Public NS	IGT	\$ 5,056.69	\$ 11,539.69
6	800-12-0000-00110	Yoakum County Hospital	Yoakum County Hospital District	Public NS	IGT	\$ 9,171.82	\$ 20,930.67
						<b>\$ 68,621,015.16</b>	<b>\$ 156,597,478.68</b>

<b>Payment Totals</b>	Total State Share	\$ 68,621,015.16
	Total Federal Share	\$ 87,976,463.52
	Total Paid	\$ 156,597,478.68



TEXAS HEALTH AND HUMAN SERVICES COMMISSION  
 1115 WAIVER QUARTERLY PAYMENTS AND STATE MATCHING SHARE SUMMARY

STC 37(b)  
 FY 2021 Q3

Uncompensated Care (UC) Program - Hospitals/Physicians Payment Detail

Provider	City of Houston	Govt Affiliation	Federal Category of Service	Source of State Match	IGT Total DY UC Pmt Pd 3Q21	Payment Total UC Dental Pd 3Q21
City of Houston	City of Houston		UC Dental	IGT	\$ 116,836.29	\$ 339,049.00
					<b>\$ 116,836.29</b>	<b>\$ 339,049.00</b>

Total State Share	\$ 116,836.29
Total Federal Share	\$ 222,212.71
Total Paid	\$ 339,049.00

TEXAS HEALTH AND HUMAN SERVICES COMMISSION  
1115 WAIVER QUARTERLY PAYMENTS AND STATE MATCHING SHARE SUMMARY  
STC 37(b)  
FY 2021 Q3  
Uncompensated Care (UC) Ambulance Payment Detail

Provider	Govt Affiliation	Source State Match	Payment Total
			UC Pmt Pd 3Q21 Federal Share Only
There were not any UC Ambulance payments made in 3Q21			
			\$ -
Payment Totals			
		Total Federal Share	\$ -
		Total Computable	\$ -

\* Payments for Ambulance Program is based on CPE therefore payments are Federal Share only

TEXAS HEALTH AND HUMAN SERVICES COMMISSION  
1115 WAIVER QUARTERLY PAYMENTS AND STATE MATCHING SHARE SUMMARY  
STC 37(b)  
FY 2021 Q3

**UC Accounts Receivable processed in 3Q21**

Provider	Government Entity	All Funds Amount	State Share	Federal Share	Program	ARTS Claim #
Fisher County Hospital	Fisher County Hospital District	\$ 296,841.00	\$ 120,814.29	\$ 176,026.71	UC	1839799
FISHER COUNTY HOSPITAL DISTRICT	Fisher County Hospital District	\$ 417,463.00	\$ 172,453.97	\$ 245,009.03	UC	1839776
UT Medical Branch Galveston	UT Medical Branch Galveston	\$ 4,123,376.00	\$ 1,678,214.03	\$ 2,445,161.97	UC	1842103
Texas West Oaks Hospital LP	Harris SDA	\$ 24,552.11	\$ 8,614.18	\$ 15,937.93	UC	1845490
<b>UC Totals</b>		<b>\$ 4,862,232.11</b>	<b>\$ 1,980,096.46</b>	<b>\$ 2,882,135.65</b>		

**DSRIP Accounts Receivable processed in 3Q21**

Provider	Government Entity	All Funds Amount	State Share	Federal Share	Program	ARTS Claim #
Seminole HD of Gaines Co dba Memorial Hospital	Seminole Hospital District of Gaines County (Memorial H	\$ 117,067.92	\$ 51,299.16	\$ 65,768.76	DSRIP	1834314
Seminole HD of Gaines Co dba Memorial Hospital	Seminole Hospital District of Gaines County (Memorial H	\$ 115,627.22	\$ 49,858.46	\$ 65,768.76	DSRIP	1834310
Tyler County Hospital	Tyler County Hospital	\$ 62,105.91	\$ 20,439.05	\$ 41,666.86	DSRIP	1855536
Memorial Hermann Hospital Southwest dba Memorial H	Harris County Hospital District	\$ 24,786.51	\$ 8,157.24	\$ 16,629.27	DSRIP	1855539
Memorial Hermann Hospital System (The Woodlands)	Harris County Hospital District	\$ 214,030.03	\$ 70,437.28	\$ 143,592.75	DSRIP	1855529
Memorial Hermann Hospital System (The Woodlands)	Harris County Hospital District	\$ 80,261.26	\$ 26,413.98	\$ 53,847.28	DSRIP	1855530
Memorial Hermann Hospital System (The Woodlands)	Harris County Hospital District	\$ 53,507.51	\$ 17,609.32	\$ 35,898.19	DSRIP	1855529
Memorial Hermann Hospital System (The Woodlands)	Harris County Hospital District	\$ 54,723.59	\$ 18,009.53	\$ 36,714.06	DSRIP	1855531
Memorial Hermann Hospital System (The Woodlands)	Harris County Hospital District	\$ 836,630.25	\$ 275,335.02	\$ 561,295.23	DSRIP	1855531
Memorial Hermann Hospital System (The Woodlands)	Harris County Hospital District	\$ 204,509.62	\$ 85,505.47	\$ 119,004.15	DSRIP	1855532
Memorial Hermann Hospital System (The Woodlands)	Harris County Hospital District	\$ 836,630.25	\$ 275,335.02	\$ 561,295.23	DSRIP	1855531
Memorial Hermann Hospital System (The Woodlands)	Harris County Hospital District	\$ 102,254.81	\$ 42,752.74	\$ 59,502.07	DSRIP	1855532
Memorial Hermann Hospital System (The Woodlands)	Harris County Hospital District	\$ 143,926.29	\$ 47,366.14	\$ 96,560.15	DSRIP	1855530
Memorial Hermann Hospital System (The Woodlands)	Harris County Hospital District	\$ 294,394.69	\$ 96,885.29	\$ 197,509.40	DSRIP	1855531
<b>DSRIP Totals</b>		<b>\$ 3,140,455.86</b>	<b>\$ 1,085,403.71</b>	<b>\$ 2,055,052.15</b>		

**From:** [Young, Gary \(HHSC\)](#)  
**To:** [Cash, Judith \(CMS/CMCS\)](#); [Garner, Angela D. \(CMS/CMCS\)](#); [Stephens, Stephanie \(HHSC\)](#)  
**Cc:** [Tsai, Daniel \(CMS/OA\)](#); [Marunycz, Lisa \(CMS/CMCS\)](#); [Kristian, Diona \(CMS/CMCS\)](#); [Greenfield, Eli S. \(CMS/CMCS\)](#); [O'Malley, Kathleen \(CMS/CMCS\)](#); [Smith, Raven \(CMS/CMCS\)](#)  
**Subject:** Re: DSRIP questions  
**Date:** Tuesday, August 24, 2021 8:39:14 PM

---

Hi Judith - Thanks. We look forward to tomorrow morning's call. Let us know when you have some availability Friday to talk about DSRIP and health equity requirements.

Thanks.

Gary

---

**From:** Cash, Judith (CMS/CMCS) <Judith.Cash@cms.hhs.gov>  
**Sent:** Tuesday, August 24, 2021 7:00 PM  
**To:** Young, Gary (HHSC) <gary.young@hhs.texas.gov>; Garner, Angela D. (CMS/CMCS) <Angela.Garner@cms.hhs.gov>; Stephens, Stephanie (HHSC) <Stephanie.Stephens01@hhs.texas.gov>  
**Cc:** Tsai, Daniel (CMS/OA) <Daniel.Tsai@cms.hhs.gov>; Marunycz, Lisa (CMS/CMCS) <Lisa.Marunycz@cms.hhs.gov>; Kristian, Diona (CMS/CMCS) <Diona.Kristian@cms.hhs.gov>; Greenfield, Eli S. (CMS/CMCS) <Eli.Greenfield@cms.hhs.gov>; O'Malley, Kathleen (CMS/CMCS) <Kathleen.OMalley@cms.hhs.gov>; Smith, Raven (CMS/CMCS) <Raven.Smith@cms.hhs.gov>  
**Subject:** RE: DSRIP questions

Hi, Gary.

Angela's team can talk through the amendment issues. But we'll need others (including me) for the conversation about the health equity metrics. I am out tomorrow and Thursday. Can we try to find time for that on Friday or Monday? I appreciate your flexibility.

Judith

---

**From:** Young, Gary (HHSC) <gary.young@hhs.texas.gov>  
**Sent:** Tuesday, August 24, 2021 6:42 PM  
**To:** Garner, Angela D. (CMS/CMCS) <Angela.Garner@cms.hhs.gov>; Cash, Judith (CMS/CMCS) <Judith.Cash@cms.hhs.gov>; Stephens, Stephanie (HHSC) <Stephanie.Stephens01@hhs.texas.gov>  
**Cc:** Tsai, Daniel (CMS/OA) <Daniel.Tsai@cms.hhs.gov>; Marunycz, Lisa (CMS/CMCS) <Lisa.Marunycz@cms.hhs.gov>; Kristian, Diona (CMS/CMCS) <Diona.Kristian@cms.hhs.gov>; Greenfield, Eli S. (CMS/CMCS) <Eli.Greenfield@cms.hhs.gov>; O'Malley, Kathleen (CMS/CMCS) <Kathleen.OMalley@cms.hhs.gov>  
**Subject:** Re: DSRIP questions

Hi Angela - We'd like to take the 10 am Eastern (9 am local) time slot. We'd like to go over the questions we submitted yesterday, but also get some specific details from CMS staff regarding the Health Equity requirements.

Thanks,

Gary

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**From:** Garner, Angela D. (CMS/CMCS) <[Angela.Garner@cms.hhs.gov](mailto:Angela.Garner@cms.hhs.gov)>

**Sent:** Tuesday, August 24, 2021 3:34 PM

**To:** Cash, Judith (CMS/CMCS) <[Judith.Cash@cms.hhs.gov](mailto:Judith.Cash@cms.hhs.gov)>; Stephens,Stephanie (HHSC) <[Stephanie.Stephens01@hhs.texas.gov](mailto:Stephanie.Stephens01@hhs.texas.gov)>

**Cc:** Young,Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>; Tsai, Daniel (CMS/OA) <[Daniel.Tsai@cms.hhs.gov](mailto:Daniel.Tsai@cms.hhs.gov)>; Marunycz, Lisa (CMS/CMCS) <[Lisa.Marunycz@cms.hhs.gov](mailto:Lisa.Marunycz@cms.hhs.gov)>; Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>; Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>; O'Malley, Kathleen (CMS/CMCS) <[Kathleen.OMalley@cms.hhs.gov](mailto:Kathleen.OMalley@cms.hhs.gov)>

**Subject:** RE: DSRIP questions

Hey Gary,

Does 10 – 11 AM EST tomorrow work for your team?

We also have availability at 3 or 4 PM EST.

Please let us know.

Thanks,

Angela

---

**From:** Cash, Judith (CMS/CMCS)

**Sent:** Tuesday, August 24, 2021 4:26 PM

**To:** Stephens,Stephanie (HHSC) <[Stephanie.Stephens01@hhs.texas.gov](mailto:Stephanie.Stephens01@hhs.texas.gov)>

**Cc:** Young,Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>; Tsai, Daniel (CMS/OA) <[Daniel.Tsai@cms.hhs.gov](mailto:Daniel.Tsai@cms.hhs.gov)>; Garner, Angela D. (CMS/CMCS) <[Angela.Garner@cms.hhs.gov](mailto:Angela.Garner@cms.hhs.gov)>; Marunycz, Lisa (CMS/CMCS) <[Lisa.Marunycz@cms.hhs.gov](mailto:Lisa.Marunycz@cms.hhs.gov)>; Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>

**Subject:** RE: DSRIP questions

Sure.

Unfortunately, I have to be out tomorrow and Thursday. But Angela and her team will make themselves available if you would like to meet before Friday. I'm looping in Angela and Diona to schedule.

Judith

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**From:** Stephens,Stephanie (HHSC) <[Stephanie.Stephens01@hhs.texas.gov](mailto:Stephanie.Stephens01@hhs.texas.gov)>

**Sent:** Tuesday, August 24, 2021 3:38 PM

**To:** Cash, Judith (CMS/CMCS) <[Judith.Cash@cms.hhs.gov](mailto:Judith.Cash@cms.hhs.gov)>

**Cc:** Young,Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>; Tsai, Daniel (CMS/OA) <[Daniel.Tsai@cms.hhs.gov](mailto:Daniel.Tsai@cms.hhs.gov)>

**Subject:** RE: DSRIP questions

Hi Judith – I chatted with Dan yesterday about setting up a meeting to explore the DSRIP extension option and talk through the questions we sent you. Can Gary work with someone to get this scheduled as soon as possible? Thanks, Stephanie

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**From:** Cash, Judith (CMS/CMCS) <[Judith.Cash@cms.hhs.gov](mailto:Judith.Cash@cms.hhs.gov)>

**Sent:** Monday, August 23, 2021 1:58 PM

**To:** Young,Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>; Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Montalbano,Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers,Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; Bilse,Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>; Stephens,Stephanie (HHSC) <[Stephanie.Stephens01@hhs.texas.gov](mailto:Stephanie.Stephens01@hhs.texas.gov)>; Deboy, Alissa M. (CMS/CMCS) <[alissa.deboy1@cms.hhs.gov](mailto:alissa.deboy1@cms.hhs.gov)>; Smith, Carrie A. (CMS/CMCS) <[Carrie.Smith@cms.hhs.gov](mailto:Carrie.Smith@cms.hhs.gov)>; Howe,

Rory (CMS/CMCS) <[Rory.Howe@cms.hhs.gov](mailto:Rory.Howe@cms.hhs.gov)>; DeCaro, Teresa (CMS/CMCS) <[teresa.decaro@cms.hhs.gov](mailto:teresa.decaro@cms.hhs.gov)>; Rashid, Mehreen (CMS/CMCS) <[mehreen.rashid@cms.hhs.gov](mailto:mehreen.rashid@cms.hhs.gov)>; Clark, Elizabeth (CMS/CMCS) <[Elizabeth.Clark@cms.hhs.gov](mailto:Elizabeth.Clark@cms.hhs.gov)>

**Cc:** HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>

**Subject:** RE: DSRIP questions

Thanks, Gary.

I'll actually ask the 1115 team to take a look at these, since they are related to a possible amendment to the demonstration.

Judith

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**From:** Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>

**Sent:** Monday, August 23, 2021 2:55 PM

**To:** Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers, Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; Bilse, Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>; Stephens, Stephanie (HHSC) <[Stephanie.Stephens01@hhs.texas.gov](mailto:Stephanie.Stephens01@hhs.texas.gov)>; Cash, Judith (CMS/CMCS) <[Judith.Cash@cms.hhs.gov](mailto:Judith.Cash@cms.hhs.gov)>; Deboy, Alissa M. (CMS/CMCS) <[alissa.deboy1@cms.hhs.gov](mailto:alissa.deboy1@cms.hhs.gov)>; Smith, Carrie A. (CMS/CMCS) <[Carrie.Smith@cms.hhs.gov](mailto:Carrie.Smith@cms.hhs.gov)>; Howe, Rory (CMS/CMCS) <[Rory.Howe@cms.hhs.gov](mailto:Rory.Howe@cms.hhs.gov)>; DeCaro, Teresa (CMS/CMCS) <[teresa.decaro@cms.hhs.gov](mailto:teresa.decaro@cms.hhs.gov)>; Rashid, Mehreen (CMS/CMCS) <[mehreen.rashid@cms.hhs.gov](mailto:mehreen.rashid@cms.hhs.gov)>; Clark, Elizabeth (CMS/CMCS) <[Elizabeth.Clark@cms.hhs.gov](mailto:Elizabeth.Clark@cms.hhs.gov)>

**Cc:** HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>

**Subject:** DSRIP questions

John and CMS Colleagues:

Texas has some questions regarding the DSRIP extension option and waiver amendment process. Please see the attached document.

Thanks.

Gary

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**From:** Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>

**Sent:** Friday, August 20, 2021 9:49 AM

**To:** HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers, Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; Bilse, Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>; Stephens, Stephanie (HHSC) <[Stephanie.Stephens01@hhs.texas.gov](mailto:Stephanie.Stephens01@hhs.texas.gov)>; Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>; Cash, Judith (CMS/CMCS) <[Judith.Cash@cms.hhs.gov](mailto:Judith.Cash@cms.hhs.gov)>; Deboy, Alissa M. (CMS/CMCS) <[alissa.deboy1@cms.hhs.gov](mailto:alissa.deboy1@cms.hhs.gov)>; Smith, Carrie A. (CMS/CMCS) <[Carrie.Smith@cms.hhs.gov](mailto:Carrie.Smith@cms.hhs.gov)>; Howe, Rory (CMS/CMCS) <[Rory.Howe@cms.hhs.gov](mailto:Rory.Howe@cms.hhs.gov)>; DeCaro, Teresa (CMS/CMCS) <[teresa.decaro@cms.hhs.gov](mailto:teresa.decaro@cms.hhs.gov)>; Rashid, Mehreen (CMS/CMCS) <[mehreen.rashid@cms.hhs.gov](mailto:mehreen.rashid@cms.hhs.gov)>; Clark, Elizabeth (CMS/CMCS) <[Elizabeth.Clark@cms.hhs.gov](mailto:Elizabeth.Clark@cms.hhs.gov)>

**Subject:** Call with TX on SFY 2022 Preprints

**When:** Friday, August 20, 2021 12:00 PM-1:00 PM.

**Where:** <https://cms.zoomgov.com/j/1610257688?pwd=N0FBTHU2QTRZdWpVK21mWmpYL1Njdz09>

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<sip:1610257688.522776@sip.zoomgov.com>

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**From:** [Young, Gary \(HHSC\)](#)  
**To:** [Garner, Angela D. \(CMS/CMCS\)](#); [Cash, Judith \(CMS/CMCS\)](#); [Stephens, Stephanie \(HHSC\)](#)  
**Cc:** [Tsai, Daniel \(CMS/OA\)](#); [Marunycz, Lisa \(CMS/CMCS\)](#); [Kristian, Diona \(CMS/CMCS\)](#); [Greenfield, Eli S. \(CMS/CMCS\)](#); [O'Malley, Kathleen \(CMS/CMCS\)](#)  
**Subject:** Re: DSRIP questions  
**Date:** Tuesday, August 24, 2021 4:51:31 PM

---

Hi Angela - I'm checking.

Gary

---

**From:** Garner, Angela D. (CMS/CMCS) <Angela.Garner@cms.hhs.gov>  
**Sent:** Tuesday, August 24, 2021 3:34 PM  
**To:** Cash, Judith (CMS/CMCS) <Judith.Cash@cms.hhs.gov>; Stephens, Stephanie (HHSC) <Stephanie.Stephens01@hhs.texas.gov>  
**Cc:** Young, Gary (HHSC) <gary.young@hhs.texas.gov>; Tsai, Daniel (CMS/OA) <Daniel.Tsai@cms.hhs.gov>; Marunycz, Lisa (CMS/CMCS) <Lisa.Marunycz@cms.hhs.gov>; Kristian, Diona (CMS/CMCS) <Diona.Kristian@cms.hhs.gov>; Greenfield, Eli S. (CMS/CMCS) <Eli.Greenfield@cms.hhs.gov>; O'Malley, Kathleen (CMS/CMCS) <Kathleen.OMalley@cms.hhs.gov>  
**Subject:** RE: DSRIP questions

Hey Gary,  
Does 10 – 11 AM EST tomorrow work for your team?  
We also have availability at 3 or 4 PM EST.  
Please let us know.  
Thanks,  
Angela

---

**From:** Cash, Judith (CMS/CMCS)  
**Sent:** Tuesday, August 24, 2021 4:26 PM  
**To:** Stephens, Stephanie (HHSC) <Stephanie.Stephens01@hhs.texas.gov>  
**Cc:** Young, Gary (HHSC) <gary.young@hhs.texas.gov>; Tsai, Daniel (CMS/OA) <Daniel.Tsai@cms.hhs.gov>; Garner, Angela D. (CMS/CMCS) <Angela.Garner@cms.hhs.gov>; Marunycz, Lisa (CMS/CMCS) <Lisa.Marunycz@cms.hhs.gov>; Kristian, Diona (CMS/CMCS) <Diona.Kristian@cms.hhs.gov>  
**Subject:** RE: DSRIP questions  
Sure.  
Unfortunately, I have to be out tomorrow and Thursday. But Angela and her team will make themselves available if you would like to meet before Friday. I'm looping in Angela and Diona to schedule.  
Judith

---

**From:** Stephens, Stephanie (HHSC) <[Stephanie.Stephens01@hhs.texas.gov](mailto:Stephanie.Stephens01@hhs.texas.gov)>  
**Sent:** Tuesday, August 24, 2021 3:38 PM  
**To:** Cash, Judith (CMS/CMCS) <[Judith.Cash@cms.hhs.gov](mailto:Judith.Cash@cms.hhs.gov)>  
**Cc:** Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>; Tsai, Daniel (CMS/OA) <[Daniel.Tsai@cms.hhs.gov](mailto:Daniel.Tsai@cms.hhs.gov)>  
**Subject:** RE: DSRIP questions



Hi Judith – I chatted with Dan yesterday about setting up a meeting to explore the DSRIP extension option and talk through the questions we sent you. Can Gary work with someone to get this scheduled as soon as possible? Thanks, Stephanie

---

**From:** Cash, Judith (CMS/CMCS) <[Judith.Cash@cms.hhs.gov](mailto:Judith.Cash@cms.hhs.gov)>

**Sent:** Monday, August 23, 2021 1:58 PM

**To:** Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>; Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers, Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; Bilse, Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>; Stephens, Stephanie (HHSC) <[Stephanie.Stephens01@hhs.texas.gov](mailto:Stephanie.Stephens01@hhs.texas.gov)>; Deboy, Alissa M. (CMS/CMCS) <[alissa.deboy1@cms.hhs.gov](mailto:alissa.deboy1@cms.hhs.gov)>; Smith, Carrie A. (CMS/CMCS) <[Carrie.Smith@cms.hhs.gov](mailto:Carrie.Smith@cms.hhs.gov)>; Howe, Rory (CMS/CMCS) <[Rory.Howe@cms.hhs.gov](mailto:Rory.Howe@cms.hhs.gov)>; DeCaro, Teresa (CMS/CMCS) <[teresa.decaro@cms.hhs.gov](mailto:teresa.decaro@cms.hhs.gov)>; Rashid, Mehreen (CMS/CMCS) <[mehreen.rashid@cms.hhs.gov](mailto:mehreen.rashid@cms.hhs.gov)>; Clark, Elizabeth (CMS/CMCS) <[Elizabeth.Clark@cms.hhs.gov](mailto:Elizabeth.Clark@cms.hhs.gov)>

**Cc:** HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>

**Subject:** RE: DSRIP questions

Thanks, Gary.

I'll actually ask the 1115 team to take a look at these, since they are related to a possible amendment to the demonstration.

Judith

---

**From:** Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>

**Sent:** Monday, August 23, 2021 2:55 PM

**To:** Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers, Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; Bilse, Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>; Stephens, Stephanie (HHSC) <[Stephanie.Stephens01@hhs.texas.gov](mailto:Stephanie.Stephens01@hhs.texas.gov)>; Cash, Judith (CMS/CMCS) <[Judith.Cash@cms.hhs.gov](mailto:Judith.Cash@cms.hhs.gov)>; Deboy, Alissa M. (CMS/CMCS) <[alissa.deboy1@cms.hhs.gov](mailto:alissa.deboy1@cms.hhs.gov)>; Smith, Carrie A. (CMS/CMCS) <[Carrie.Smith@cms.hhs.gov](mailto:Carrie.Smith@cms.hhs.gov)>; Howe, Rory (CMS/CMCS) <[Rory.Howe@cms.hhs.gov](mailto:Rory.Howe@cms.hhs.gov)>; DeCaro, Teresa (CMS/CMCS) <[teresa.decaro@cms.hhs.gov](mailto:teresa.decaro@cms.hhs.gov)>; Rashid, Mehreen (CMS/CMCS) <[mehreen.rashid@cms.hhs.gov](mailto:mehreen.rashid@cms.hhs.gov)>; Clark, Elizabeth (CMS/CMCS) <[Elizabeth.Clark@cms.hhs.gov](mailto:Elizabeth.Clark@cms.hhs.gov)>

**Cc:** HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>

**Subject:** DSRIP questions

John and CMS Colleagues:

Texas has some questions regarding the DSRIP extension option and waiver amendment process. Please see the attached document.

Thanks.

Gary

---

**From:** Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>

**Sent:** Friday, August 20, 2021 9:49 AM

**To:** HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers, Courtney (HHSC)

<[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; Bilse,Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>; Stephens,Stephanie (HHSC) <[Stephanie.Stephens01@hhs.texas.gov](mailto:Stephanie.Stephens01@hhs.texas.gov)>; Young,Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>; Cash, Judith (CMS/CMCS) <[Judith.Cash@cms.hhs.gov](mailto:Judith.Cash@cms.hhs.gov)>; Deboy, Alissa M. (CMS/CMCS) <[alissa.deboy1@cms.hhs.gov](mailto:alissa.deboy1@cms.hhs.gov)>; Smith, Carrie A. (CMS/CMCS) <[Carrie.Smith@cms.hhs.gov](mailto:Carrie.Smith@cms.hhs.gov)>; Howe, Rory (CMS/CMCS) <[Rory.Howe@cms.hhs.gov](mailto:Rory.Howe@cms.hhs.gov)>; DeCaro, Teresa (CMS/CMCS) <[teresa.decaro@cms.hhs.gov](mailto:teresa.decaro@cms.hhs.gov)>; Rashid, Mehreen (CMS/CMCS) <[mehreen.rashid@cms.hhs.gov](mailto:mehreen.rashid@cms.hhs.gov)>; Clark, Elizabeth (CMS/CMCS) <[Elizabeth.Clark@cms.hhs.gov](mailto:Elizabeth.Clark@cms.hhs.gov)>

**Subject:** Call with TX on SFY 2022 Preprints

**When:** Friday, August 20, 2021 12:00 PM-1:00 PM.

**Where:** <https://cms.zoomgov.com/j/1610257688?pwd=N0FBTHU2QTRZdWpVK21mWmpYL1Njdz09>

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**From:** [Cash, Judith \(CMS/CMCS\)](#)  
**To:** [Hill, Elizabeth H. \(CMS/CMCS\)](#)  
**Subject:** FW: Follow-up  
**Date:** Wednesday, September 8, 2021 3:22:42 PM

---

---

**From:** Young, Gary (HHSC) <gary.young@hhs.texas.gov>  
**Sent:** Tuesday, August 24, 2021 3:05 PM  
**To:** Cash, Judith (CMS/CMCS) <Judith.Cash@cms.hhs.gov>; Giles, John (CMS/CMCS) <John.Giles1@cms.hhs.gov>; Snyder, Laura M. (CMS/CMCS) <Laura.Snyder1@cms.hhs.gov>  
**Cc:** Stephens, Stephanie (HHSC) <Stephanie.Stephens01@hhs.texas.gov>; Montalbano, Kathi (HHSC) <Kathi.Montalbano@hhs.texas.gov>; HHSC TX Medicaid Waivers <TX\_Medicaid\_Waivers@hhs.texas.gov>  
**Subject:** Follow-up

Judith, John, Laura and CMS colleagues:

Thanks so much for arranging today's call. It was quite helpful and the advice we received is greatly appreciated.

We will be following-up with written questions tomorrow. We're thinking Thursdays' call would be an opportunity for additional discussion of the quality issues for the first 30 minutes, and the second half a discussion with FMG on their concerns. We're also open to other matters your staff would like to review with us.

Thanks again.

Gary

**From:** [Cash, Judith \(CMS/CMCS\)](#)  
**To:** [Hill, Elizabeth H. \(CMS/CMCS\)](#)  
**Subject:** FW: DSRIP questions  
**Date:** Wednesday, September 8, 2021 3:21:42 PM  
**Attachments:** [20210823\\_1115 Waiver Amendment Process.docx](#)

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**From:** Young, Gary (HHSC) <gary.young@hhs.texas.gov>  
**Sent:** Monday, August 23, 2021 2:55 PM  
**To:** Giles, John (CMS/CMCS) <John.Giles1@cms.hhs.gov>; HHSC TX Medicaid Waivers <TX\_Medicaid\_Waivers@hhs.texas.gov>; Montalbano, Kathi (HHSC) <Kathi.Montalbano@hhs.texas.gov>; Caruthers, Courtney (HHSC) <Courtney.Caruthers@hhs.texas.gov>; Bilse, Brittani (HHSC) <Brittani.Bilse@hhs.texas.gov>; Stephens, Stephanie (HHSC) <Stephanie.Stephens01@hhs.texas.gov>; Cash, Judith (CMS/CMCS) <Judith.Cash@cms.hhs.gov>; Deboy, Alissa M. (CMS/CMCS) <alissa.deboy1@cms.hhs.gov>; Smith, Carrie A. (CMS/CMCS) <Carrie.Smith@cms.hhs.gov>; Howe, Rory (CMS/CMCS) <Rory.Howe@cms.hhs.gov>; DeCaro, Teresa (CMS/CMCS) <teresa.decaro@cms.hhs.gov>; Rashid, Mehreen (CMS/CMCS) <mehreen.rashid@cms.hhs.gov>; Clark, Elizabeth (CMS/CMCS) <Elizabeth.Clark@cms.hhs.gov>  
**Cc:** HHSC TX Medicaid Waivers <TX\_Medicaid\_Waivers@hhs.texas.gov>  
**Subject:** DSRIP questions

John and CMS Colleagues:

Texas has some questions regarding the DSRIP extension option and waiver amendment process. Please see the attached document.

Thanks.

Gary

---

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### **1115 Waiver Amendment Timelines**

- The standard process for HHSC to amend the 1115 waiver takes at least 6 months, and typically longer, and includes the following steps:
  - *Tribal notice* - HHSC provides tribal notice 60 days prior to submission of the waiver amendment to CMS, pursuant to the state's tribal consultation agreement. The agreement specifies that this timeframe "may change if the state is required to submit these documents to CMS in less time." For state plan amendments, the state plan specifies a minimum timeframe of no less than one calendar week for certain instances requiring an expedited process and defines examples of certain instances to include: direction from Texas state leadership; direction from CMS; a court order; a settlement agreement; federal rules, regulations, or laws; or state or federal legislation.
  - *Public notice* – HHSC provides public notice and comment period 45 days prior to submission of the waiver amendment to CMS. This occurs concurrently with tribal notice. Pursuant to 42 Code of Federal Regulations § 431.408, "a State must provide at least a 30-day public notice and comment period regarding *applications for a demonstration project, or an extension of an existing demonstration project that the State intends to submit to CMS for review and consideration.*" The regulation does not address waiver amendments.
  - *Waiver amendment submission* – HHSC submits to CMS an 1115 waiver amendment at least 120 days prior to the effective date, pursuant to the waiver Special Terms and Conditions (STC) 7. STC 7 requires that "requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved." This STC also requires amendment requests to include an explanation of the public process used by the state. In addition, STC 6 provides in pertinent part that "[a]mendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 7."

### **DSRIP Timelines**

- The performance period for Category A, B, and D DSRIP measures is the federal fiscal year, starting October 1. The measurement year for Category C DSRIP measures is the calendar year.

### **Questions for CMS**

- Regarding the DSRIP extension option, CMS has mentioned 30 days for the federal public comment period and a 15-day period after the federal comment period. What is CMS assuming regarding the 120-day period required under STC 7? What is CMS assuming regarding any requirements regarding state public notice and any timeline for the state's public comment period?
- Based on required timelines, it does not seem possible for a DSRIP extension to be approved before October 1, which is the start of the performance period for certain DSRIP measures. Will DSRIP funding be available for performance starting October 1 if a waiver amendment were approved after October 1? What is CMS' position as to the issues created by STC 6 which does not appear to allow for retroactive approvals and does not allow for FFP for retroactive approvals?
- Will CMS approve flexibilities in demonstrating DSRIP achievement and determining payment for 2021 and 2022 due to the ongoing COVID-19 public health emergency? Without flexibilities, DSRIP participating providers will be unable to earn available DSRIP funding due to changes in health care access and utilization that are outside of their control.
- Will CMS please confirm that the existing sources of non-federal share used in DSRIP (i.e., LPPFs) will be permissible for the one-year extension as well?
- DSRIP payments would be made in federal fiscal year 2022 and 2023 for performance in Demonstration Year 11 (federal fiscal year 2022 and calendar year 2022). HHSC seeks confirmation that HHSC could continue to make DSRIP payments on the current payment schedule.

**From:** [HHSC TX Medicaid Waivers](#)  
**To:** [Kristian, Diona \(CMS/CMCS\)](#); [Greenfield, Eli S. \(CMS/CMCS\)](#); [Blunt, Ford J. \(CMS/CMCS\)](#)  
**Cc:** [Montalbano, Kathi \(HHSC\)](#); [Caruthers, Courtney \(HHSC\)](#); [Young, Gary \(HHSC\)](#); [Bilse, Brittani \(HHSC\)](#); [Roland, Dawn \(HHSC\)](#)  
**Subject:** Agenda Items for August 26 2021 CMS Call  
**Date:** Friday, August 20, 2021 10:35:29 AM  
**Attachments:** [image001.png](#)

---

Good morning,

Please let us know if you have any agenda items for our 1115 Monthly Monitoring CMS and HHSC call scheduled for Thursday, August 26, 2021 at 1:30 p.m.

Thank you.

Sincerely,

*Dawn M. Roland*

Dawn M. Roland, B.S.ED., CMP, CWM  
1915(c), 1915(b), 1915(i) Waivers Program Specialist II  
Policy Development Support  
Medicaid/CHIP Services  
**Texas Health and Human Services Commission**  
[Dawn.Roland@hhs.texas.gov](mailto:Dawn.Roland@hhs.texas.gov)



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**From:** [Young, Gary \(HHSC\)](#)  
**To:** [Giles, John \(CMS/CMCS\)](#); [CMS State Directed Payment](#); [Montalbano, Kathi \(HHSC\)](#); [Caruthers, Courtney \(HHSC\)](#); [Grady, Victoria C \(HHSC\)](#); [HHSC TX Medicaid Waivers](#); [Bilse, Brittani \(HHSC\)](#); [Zalkovsky, Emily \(HHSC\)](#); [Diseker, Sarah \(HHSC\)](#)  
**Cc:** [Snyder, Laura M. \(CMS/CMCS\)](#); [Greenfield, Eli S. \(CMS/CMCS\)](#); [Kristian, Diona \(CMS/CMCS\)](#); [Kuhn, Juliet L. \(CMS/CMCS\)](#)  
**Subject:** Re: Call with CMS to Discuss SFY 2022 Preprints  
**Date:** Tuesday, August 17, 2021 5:45:54 PM

---

Got it, Thanks.

---

**From:** Giles, John (CMS/CMCS) <John.Giles1@cms.hhs.gov>  
**Sent:** Tuesday, August 17, 2021 4:42 PM  
**To:** Young, Gary (HHSC) <gary.young@hhs.texas.gov>; CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>; Montalbano, Kathi (HHSC) <Kathi.Montalbano@hhs.texas.gov>; Caruthers, Courtney (HHSC) <Courtney.Caruthers@hhs.texas.gov>; Grady, Victoria C (HHSC) <Victoria.Grady@hhs.texas.gov>; HHSC TX Medicaid Waivers <TX\_Medicaid\_Waivers@hhs.texas.gov>; Bilse, Brittani (HHSC) <Brittani.Bilse@hhs.texas.gov>; Zalkovsky, Emily (HHSC) <Emily.Zalkovsky@hhs.texas.gov>; Diseker, Sarah (HHSC) <Sarah.Diseker@hhs.texas.gov>  
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**Subject:** RE: Call with CMS to Discuss SFY 2022 Preprints  
Texas Team –  
We just resent the meeting invite for tomorrow at 2pm. Juliet Kuhn will pull down the 11am meeting first thing tomorrow morning.  
Thank you again,  
John Giles

---

**From:** Giles, John (CMS/CMCS)  
**Sent:** Tuesday, August 17, 2021 5:27 PM  
**To:** Young, Gary (HHSC) <gary.young@hhs.texas.gov>; CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>; Montalbano, Kathi (HHSC) <Kathi.Montalbano@hhs.texas.gov>; Caruthers, Courtney (HHSC) <Courtney.Caruthers@hhs.texas.gov>; Grady, Victoria C (HHSC) <Victoria.Grady@hhs.texas.gov>; HHSC TX Medicaid Waivers <TX\_Medicaid\_Waivers@hhs.texas.gov>; Bilse, Brittani (HHSC) <Brittani.Bilse@hhs.texas.gov>; Zalkovsky, Emily (HHSC) <Emily.Zalkovsky@hhs.texas.gov>; Diseker, Sarah (HHSC) <Sarah.Diseker@hhs.texas.gov>  
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**Subject:** RE: Call with CMS to Discuss SFY 2022 Preprints  
Thank you Gary! We will resend the invite (although, it might come in the morning). We will plan to meet with you tomorrow at 2pm ET. Thank you!  
John Giles

---

**From:** Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>

**Sent:** Tuesday, August 17, 2021 5:25 PM

**To:** Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>; CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>; Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers, Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; Grady, Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Bilse, Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>; Zalkovsky, Emily (HHSC) <[Emily.Zalkovsky@hhs.texas.gov](mailto:Emily.Zalkovsky@hhs.texas.gov)>; Diseker, Sarah (HHSC) <[Sarah.Diseker@hhs.texas.gov](mailto:Sarah.Diseker@hhs.texas.gov)>

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**Subject:** Re: Call with CMS to Discuss SFY 2022 Preprints

Hi - We had cleared both times previously, so that should work. Please re-send the invite.

Thanks.

Gary

**From:** Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>

**Sent:** Tuesday, August 17, 2021 4:09 PM

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**Subject:** RE: Call with CMS to Discuss SFY 2022 Preprints

Hi Texas Team and Good Evening –

Can we shift this appointment to 2pm EST tomorrow? We have CMS leaders who would like to join the call tomorrow.

Thank you very much, and my apologies for the late message.

John Giles

**From:** CMS State Directed Payment

**Sent:** Tuesday, August 17, 2021 1:55 PM

**To:** Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>; Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>; Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers, Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; Grady, Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Bilse, Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>; Zalkovsky, Emily (HHSC) <[Emily.Zalkovsky@hhs.texas.gov](mailto:Emily.Zalkovsky@hhs.texas.gov)>; Diseker, Sarah (HHSC) <[Sarah.Diseker@hhs.texas.gov](mailto:Sarah.Diseker@hhs.texas.gov)>

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**Subject:** RE: Call with CMS to Discuss SFY 2022 Preprints

Thanks Gary – we will go with 11am ET tomorrow. You will see the appointment come through shortly.

Juliet

---

**From:** Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>

**Sent:** Tuesday, August 17, 2021 1:15 PM

**To:** Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>; CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>; Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers, Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; Grady, Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Bilse, Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>; Zalkovsky, Emily (HHSC) <[Emily.Zalkovsky@hhs.texas.gov](mailto:Emily.Zalkovsky@hhs.texas.gov)>; Diseker, Sarah (HHSC) <[Sarah.Diseker@hhs.texas.gov](mailto:Sarah.Diseker@hhs.texas.gov)>

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**Subject:** Re: Call with CMS to Discuss SFY 2022 Preprints

Hi John & Juliet:

Either time will work for us. Please send the invite to the Texas waiver mailbox (as above) and copy Kathi, Brittani and I. We will forward to appropriate staff.

Thanks.

Gary

---

**From:** Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>

**Sent:** Tuesday, August 17, 2021 9:24 AM

**To:** Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>; CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>; Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers, Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; Grady, Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Bilse, Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>; Zalkovsky, Emily (HHSC) <[Emily.Zalkovsky@hhs.texas.gov](mailto:Emily.Zalkovsky@hhs.texas.gov)>; Diseker, Sarah (HHSC) <[Sarah.Diseker@hhs.texas.gov](mailto:Sarah.Diseker@hhs.texas.gov)>

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**Subject:** RE: Call with CMS to Discuss SFY 2022 Preprints

Hi Gary –

It is CMS' understanding that Texas is requesting that we describe the modifications needed to each of the five preprints currently under CMS review that would be required to ensure compliance with all statutory and regulatory requirements. If Texas is able to meet on Wednesday, we can provide this information. Once we discuss, we are also willing to schedule topic-specific calls as needed.

Thanks so much!

John Giles

---

**From:** Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>

**Sent:** Tuesday, August 17, 2021 9:57 AM

**To:** CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>; Montalbano,Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers,Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; Grady,Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Bilse,Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>; Zalkovsky,Emily (HHSC) <[Emily.Zalkovsky@hhs.texas.gov](mailto:Emily.Zalkovsky@hhs.texas.gov)>; Diseker,Sarah (HHSC) <[Sarah.Diseker@hhs.texas.gov](mailto:Sarah.Diseker@hhs.texas.gov)>

**Cc:** Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>; Snyder, Laura M. (CMS/CMCS) <[Laura.Snyder1@cms.hhs.gov](mailto:Laura.Snyder1@cms.hhs.gov)>; Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>; Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>

**Subject:** Re: Call with CMS to Discuss SFY 2022 Preprints

Juliet - In order for us to have the right people on the call, can you tell me what the topic is for this initial discussion?

Thanks.

---

**From:** Young,Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>

**Sent:** Tuesday, August 17, 2021 8:37 AM

**To:** CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>; Montalbano,Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers,Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; Grady,Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Bilse,Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>; Zalkovsky,Emily (HHSC) <[Emily.Zalkovsky@hhs.texas.gov](mailto:Emily.Zalkovsky@hhs.texas.gov)>; Diseker,Sarah (HHSC) <[Sarah.Diseker@hhs.texas.gov](mailto:Sarah.Diseker@hhs.texas.gov)>

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**Subject:** Re: Call with CMS to Discuss SFY 2022 Preprints

Hi Juliet - We'll get back with you shortly.

Gary

---

**From:** CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>

**Sent:** Tuesday, August 17, 2021 7:39 AM

**To:** Montalbano,Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers,Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; Young,Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>; Grady,Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Bilse,Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>; Zalkovsky,Emily (HHSC) <[Emily.Zalkovsky@hhs.texas.gov](mailto:Emily.Zalkovsky@hhs.texas.gov)>; Diseker,Sarah (HHSC) <[Sarah.Diseker@hhs.texas.gov](mailto:Sarah.Diseker@hhs.texas.gov)>

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**Subject:** Call with CMS to Discuss SFY 2022 Preprints

**WARNING:** This email is from outside the HHS system. Do not click on links or attachments unless you expect them from the sender and know the content is safe.

Good morning Texas Team,

We wanted to see if the Texas team would be available tomorrow (Wednesday, 8/18) to discuss modifications needed for the SFY 2022 directed payment preprints. Would the state be available at 11am ET or 2pm ET tomorrow?

Many thanks,

Juliet

Juliet Kuhn, MPH

Division of Managed Care Policy

Center for Medicaid and CHIP Services

Centers for Medicare & Medicaid Services

Phone: 410-786-2480

**From:** [Young, Gary \(HHSC\)](#)  
**To:** [Giles, John \(CMS/CMCS\)](#); [CMS State Directed Payment](#); [Montalbano, Kathi \(HHSC\)](#); [Caruthers, Courtney \(HHSC\)](#); [Grady, Victoria C \(HHSC\)](#); [HHSC TX Medicaid Waivers](#); [Bilse, Brittani \(HHSC\)](#); [Zalkovsky, Emily \(HHSC\)](#); [Diseker, Sarah \(HHSC\)](#)  
**Cc:** [Snyder, Laura M. \(CMS/CMCS\)](#); [Greenfield, Eli S. \(CMS/CMCS\)](#); [Kristian, Diona \(CMS/CMCS\)](#)  
**Subject:** Re: Call with CMS to Discuss SFY 2022 Preprints  
**Date:** Tuesday, August 17, 2021 5:25:04 PM

---

Hi - We had cleared both times previously, so that should work. Please re-send the invite.

Thanks.

Gary

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**Subject:** RE: Call with CMS to Discuss SFY 2022 Preprints

Hi Texas Team and Good Evening –

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Thank you very much, and my apologies for the late message.

John Giles

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<Sarah.Diseker@hhs.texas.gov>

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**Subject:** RE: Call with CMS to Discuss SFY 2022 Preprints

Thanks Gary – we will go with 11am ET tomorrow. You will see the appointment come through shortly.

Juliet

---

**From:** Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>

**Sent:** Tuesday, August 17, 2021 1:15 PM

**To:** Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>; CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>; Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers, Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; Grady, Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Bilse, Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>; Zalkovsky, Emily (HHSC) <[Emily.Zalkovsky@hhs.texas.gov](mailto:Emily.Zalkovsky@hhs.texas.gov)>; Diseker, Sarah (HHSC) <[Sarah.Diseker@hhs.texas.gov](mailto:Sarah.Diseker@hhs.texas.gov)>

**Cc:** Snyder, Laura M. (CMS/CMCS) <[Laura.Snyder1@cms.hhs.gov](mailto:Laura.Snyder1@cms.hhs.gov)>; Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>; Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>

**Subject:** Re: Call with CMS to Discuss SFY 2022 Preprints

Hi John & Juliet:

Either time will work for us. Please send the invite to the Texas waiver mailbox (as above) and copy Kathi, Brittani and I. We will forward to appropriate staff.

Thanks.

Gary

---

**From:** Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>

**Sent:** Tuesday, August 17, 2021 9:24 AM

**To:** Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>; CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>; Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers, Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; Grady, Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Bilse, Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>; Zalkovsky, Emily (HHSC) <[Emily.Zalkovsky@hhs.texas.gov](mailto:Emily.Zalkovsky@hhs.texas.gov)>; Diseker, Sarah (HHSC) <[Sarah.Diseker@hhs.texas.gov](mailto:Sarah.Diseker@hhs.texas.gov)>

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John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>

**Subject:** RE: Call with CMS to Discuss SFY 2022 Preprints

Hi Gary –

It is CMS' understanding that Texas is requesting that we describe the modifications needed to each of the five preprints currently under CMS review that would be required to ensure compliance with all statutory and regulatory requirements. If Texas is able to meet on Wednesday, we can provide this information. Once we discuss, we are also willing to schedule topic-specific calls as needed.

Thanks so much!

John Giles

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**Sent:** Tuesday, August 17, 2021 9:57 AM

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**Subject:** Re: Call with CMS to Discuss SFY 2022 Preprints

Juliet - In order for us to have the right people on the call, can you tell me what the topic is for this initial discussion?

Thanks.

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Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>

**Subject:** Re: Call with CMS to Discuss SFY 2022 Preprints

Hi Juliet - We'll get back with you shortly.

Gary

---

**From:** CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>

**Sent:** Tuesday, August 17, 2021 7:39 AM

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**Subject:** Call with CMS to Discuss SFY 2022 Preprints

**WARNING:** This email is from outside the HHS system. Do not click on links or attachments unless you expect them from the sender and know the content is safe.

Good morning Texas Team,

We wanted to see if the Texas team would be available tomorrow (Wednesday, 8/18) to discuss modifications needed for the SFY 2022 directed payment preprints. Would the state be available at 11am ET or 2pm ET tomorrow?

Many thanks,  
Juliet

Juliet Kuhn, MPH  
Division of Managed Care Policy  
Center for Medicaid and CHIP Services  
Centers for Medicare & Medicaid Services  
Phone: 410-786-2480

**From:** [Young, Gary \(HHSC\)](#)  
**To:** [Giles, John \(CMS/CMCS\)](#); [CMS State Directed Payment](#); [Montalbano, Kathi \(HHSC\)](#); [Caruthers, Courtney \(HHSC\)](#); [Grady, Victoria C \(HHSC\)](#); [HHSC TX Medicaid Waivers](#); [Bilse, Brittani \(HHSC\)](#); [Zalkovsky, Emily \(HHSC\)](#); [Diseker, Sarah \(HHSC\)](#)  
**Cc:** [Snyder, Laura M. \(CMS/CMCS\)](#); [Greenfield, Eli S. \(CMS/CMCS\)](#); [Kristian, Diona \(CMS/CMCS\)](#)  
**Subject:** Re: Call with CMS to Discuss SFY 2022 Preprints  
**Date:** Tuesday, August 17, 2021 10:27:30 AM

---

Hi John - Thanks, I'll check with staff on their availability.

Gary

---

**From:** Giles, John (CMS/CMCS) <John.Giles1@cms.hhs.gov>  
**Sent:** Tuesday, August 17, 2021 9:24 AM  
**To:** Young, Gary (HHSC) <gary.young@hhs.texas.gov>; CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>; Montalbano, Kathi (HHSC) <Kathi.Montalbano@hhs.texas.gov>; Caruthers, Courtney (HHSC) <Courtney.Caruthers@hhs.texas.gov>; Grady, Victoria C (HHSC) <Victoria.Grady@hhs.texas.gov>; HHSC TX Medicaid Waivers <TX\_Medicaid\_Waivers@hhs.texas.gov>; Bilse, Brittani (HHSC) <Brittani.Bilse@hhs.texas.gov>; Zalkovsky, Emily (HHSC) <Emily.Zalkovsky@hhs.texas.gov>; Diseker, Sarah (HHSC) <Sarah.Diseker@hhs.texas.gov>  
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Many thanks,  
Juliet

Juliet Kuhn, MPH  
Division of Managed Care Policy  
Center for Medicaid and CHIP Services  
Centers for Medicare & Medicaid Services  
Phone: 410-786-2480

**From:** [Cash, Judith \(CMS/CMCS\)](#)  
**To:** [Hill, Elizabeth H. \(CMS/CMCS\)](#)  
**Subject:** FW: letter from CMS  
**Date:** Wednesday, September 8, 2021 3:21:17 PM  
**Attachments:** [20210816\\_Letter\\_MrTsai.pdf](#)

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---

**From:** Stephens,Stephanie (HHSC) <Stephanie.Stephens01@hhs.texas.gov>  
**Sent:** Monday, August 16, 2021 6:47 PM  
**To:** Cash, Judith (CMS/CMCS) <Judith.Cash@cms.hhs.gov>  
**Cc:** Tsai, Daniel (CMS/OA) <Daniel.Tsai@cms.hhs.gov>; Hendrix,Kate (HHSC) <Kate.Hendrix@hhs.texas.gov>  
**Subject:** RE: letter from CMS

Hi Judith,

Please see attached the state's response to your letter. We too are happy to discuss and/or address any questions.

Thanks,  
Stephanie

---

**From:** Cash, Judith (CMS/CMCS) <[Judith.Cash@cms.hhs.gov](mailto:Judith.Cash@cms.hhs.gov)>  
**Sent:** Friday, August 13, 2021 4:19 PM  
**To:** Stephens,Stephanie (HHSC) <[Stephanie.Stephens01@hhs.texas.gov](mailto:Stephanie.Stephens01@hhs.texas.gov)>  
**Cc:** Tsai, Daniel (CMS/OA) <[Daniel.Tsai@cms.hhs.gov](mailto:Daniel.Tsai@cms.hhs.gov)>; Teal, Lela (CMS/CMCS) <[Lela.Teal@cms.hhs.gov](mailto:Lela.Teal@cms.hhs.gov)>; Briskin, Perrie (CMS/OA) <[Perrie.Briskin@cms.hhs.gov](mailto:Perrie.Briskin@cms.hhs.gov)>; Cash, Judith (CMS/CMCS) <[Judith.Cash@cms.hhs.gov](mailto:Judith.Cash@cms.hhs.gov)>  
**Subject:** letter from CMS

**WARNING:** This email is from outside the HHS system. Do not click on links or attachments unless you expect them from the sender and know the content is safe.

Good afternoon, Stephanie. Please see attached letter from CMCS Director, Dan Tsai. And, please let us know if you have questions and/or want to discuss.

Judith

*Judith A. Cash*  
*Acting Deputy Director*  
*Center for Medicaid and CHIP Services*  
*Centers for Medicare and Medicaid Services*  
443-683-1957



**TEXAS**  
Health and Human  
Services

**Texas Health and Human Services Commission**

**Cecile Erwin Young**  
Executive Commissioner

August 16, 2021

Dan Tsai  
Deputy Administrator and Director  
Center for Medicaid & CHIP Services (CMCS)  
7500 Security Blvd  
Baltimore, MD 21244

Dear Mr. Tsai,

The Texas Health and Human Services Commission has received your letter dated August 13, 2021. We understand this letter is intended to comply with the court's August 12, 2021, Order to Clarify Sanctions Standards in *State of Texas v. Brooks-LaSure*.

In its August 12 order, the court gave the Centers for Medicare & Medicaid Services (CMS) two options:

- (1) withdraw or modify the representations by Judith Cash and others that CMS is treating the Demonstration Project as in effect, or
- (2) conform its conduct to the Demonstration Project's special terms and conditions (STCs) by either:
  - a. notifying the state that CMS intends to issue a formal decision within 20 days approving the relevant state-directed payment programs (SDPs); or
  - b. notifying the state why CMS does not anticipate approving the SDPs and notifying the state of specific further modifications required for approval, with that notice triggering the timing requirements of paragraph 34 for meeting to discuss those further modifications.

Dan Tsai  
August 16, 2021  
Page 2

We also understand CMS filed notice with the court claiming compliance with the court's order, specifically with option 2.

The state is pleased to begin the dialogue required by the STCs in the January 15 waiver extension. However, your letter does not provide enough information for HHSC to choose between the two options it contains. Specifically, you state that "CMS cannot approve Texas's proposed SDPs in their current form." But the letter does not, as the court required, describe the "specific further modifications required for approval" as required by the court's order.

Your letter provides two options for "modifications." In the first, CMS offers approval of two programs, one of which the state did not propose for state fiscal year 2022 and is inconsistent with the structure of the January 15 waiver extension. This is not a "modification" of the SDP proposals that have been existing since March. It appears, instead, to ask the state to agree to revert to the version of the section 1115 waiver that is currently set to expire in September 2022.

Under your second option, CMS seems to suggest that it will continue the January 15 waiver extension, but the state must "modify" the proposed SDPs by withdrawing them completely and starting over in a manner that is inconsistent with that waiver extension. The only concrete problem that the letter cites is the size of the SDPs. But the size of the SDPs has been known to CMS for months and is fully integrated into the January 15 waiver extension itself because it drives the budget neutrality baseline around which the waiver is built. If these were problems all along, the January 15 STCs obligated CMS to forthrightly state as much and to suggest potential solutions in good faith. CMS's failure to do so until now has seriously impeded HHSC's ability to implement the programs envisioned by the January 15 waiver extension.

Texas wants to work with CMS toward approval of our SDPs and is committed to finding an approach that is consistent with all applicable regulatory and statutory requirements. But we lack sufficient information to do so at the present time. In the appendix to your letter, Option 2 would require the state to submit new proposals that address five issues. However, CMS does not provide an explanation of how each program fails to meet each requirement of law. To ensure productive conversations, we ask CMS to specify which issues apply to which programs and to

Dan Tsai  
August 16, 2021  
Page 3

be prepared to discuss the specific modifications to each program that are required for approval.

We look forward to beginning regular meetings, by phone or in person, to resolve CMS's concerns. Texas staff are available to begin our regular meetings immediately. Please confirm CMS's availability and the CMS staff that will attend the meeting.

If you have any questions, please contact me at (512) 538-5335.

Sincerely,

A handwritten signature in black ink that reads "Stephanie Stephens". The signature is written in a cursive, flowing style. The first name "Stephanie" is written with a large, sweeping 'S' that extends over the second name. The second name "Stephens" is written in a similar cursive style.

Stephanie Stephens  
State Medicaid Director



**From:** [HHSC TX Medicaid Waivers](#)  
**To:** [Kristian, Diona \(CMS/CMCS\)](#)  
**Cc:** [Montalbano, Kathi \(HHSC\)](#); [Caruthers, Courtney \(HHSC\)](#); [Greenfield, Eli S. \(CMS/CMCS\)](#)  
**Subject:** RE: Confirmation of your CMS address  
**Date:** Monday, August 16, 2021 3:49:49 PM  
**Attachments:** [image001.png](#)

---

Thank you, Diona.

Sincerely,

*Dawn M. Roland*

Dawn M. Roland, B.S.ED., CMP, CWM  
1915(c), 1915(b), 1915(i) Waivers Program Specialist II  
Policy Development Support  
Medicaid/CHIP Services  
**Texas Health and Human Services Commission**  
[Dawn.Roland@hhs.texas.gov](mailto:Dawn.Roland@hhs.texas.gov)



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**From:** Kristian, Diona (CMS/CMCS) <Diona.Kristian@cms.hhs.gov>  
**Sent:** Monday, August 16, 2021 1:16 PM  
**To:** HHSC TX Medicaid Waivers <TX\_Medicaid\_Waivers@hhs.texas.gov>  
**Cc:** Montalbano, Kathi (HHSC) <Kathi.Montalbano@hhs.texas.gov>; Caruthers, Courtney (HHSC) <Courtney.Caruthers@hhs.texas.gov>; Greenfield, Eli S. (CMS/CMCS) <Eli.Greenfield@cms.hhs.gov>  
**Subject:** RE: Confirmation of your CMS address

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Hi Dawn,

My official mailing address is the following:

Centers for Medicare & Medicaid Services  
Center for Medicaid & CHIP Services  
Mail Stop: S2-25-26  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Note that I am working from home, so please send correspondence to my email. Thanks.

Diona

---

**From:** HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>  
**Sent:** Monday, August 16, 2021 12:31 PM  
**To:** Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>  
**Cc:** Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers, Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>  
**Subject:** Confirmation of your CMS address

Good morning, Diona,

I need your assistance with your current CMS mailing address. If you could please email me this address at [TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov) this would be greatly appreciated.

Thank you in advance for your help.

Sincerely,

*Dawn M. Roland*

Dawn M. Roland, B.S.ED., CMP, CWM  
1915(c), 1915(b), 1915(i) Waivers Program Specialist II  
Policy Development Support  
Medicaid/CHIP Services  
**Texas Health and Human Services Commission**  
[Dawn.Roland@hhs.texas.gov](mailto:Dawn.Roland@hhs.texas.gov)



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**From:** [Vasquez, Andy \(HHSC\)](#)  
**To:** [Kristian, Diona \(CMS/CMCS\)](#); [Boston, Natasha \(HHSC\)](#); [Carter, Wrandi \(HHSC\)](#); [Gilmore, Fiona \(HHSC\)](#); [Hughes, Sheila \(HHSC\)](#); [Jung, Joelle \(HHSC\)](#); [Morcos, Betty \(HHSC\)](#); [Podgornoff, Dottie \(HHSC\)](#); [Quereau, Jennifer \(HHSC\)](#); [Quinn, Andrea \(HHSC\)](#); [Sentilles, Emily \(HHSC\)](#); [Tucker, Kimberly \(HHSC\)](#); [Tourk, Stephanie \(HHSC\)](#); [Luna, Beverly \(HHSC\)](#); [Greenfield, Eli S. \(CMS/CMCS\)](#); [Devoid, Isaac \(CMS/CMCS\)](#); [Frankos-Rey, Andrew \(CMS/CMCS\)](#); [Khan, Rabia \(CMS/CMCS\)](#); [Garner, Angela D. \(CMS/CMCS\)](#); [Marunycz, Lisa \(CMS/CMCS\)](#); [Blunt, Ford J. \(CMS/CMCS\)](#); [Huynh, Linda \(HHSC\)](#); [Zalkovsky, Emily \(HHSC\)](#)  
**Subject:** RE: Texas/CMS Meeting on DSRIP Flexibilities  
**Date:** Thursday, August 12, 2021 1:36:38 PM  
**Attachments:** [Summary of COVID-19 Impact to TX DSRIP 2020.pdf](#)

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Dear Diona and other CMS Attendees,  
 We look forward to speaking with you soon. We committed to providing you a summary of our DY 9 results to provide a more detailed picture of the impact of COVID and the approved flexibilities on our DSRIP providers and their outcomes. We plan to step through the key points during our meeting.

Thank you,

### Andy Vasquez

Texas Health & Human Services Commission  
 Medicaid & CHIP Services Department  
 Deputy Associate Commissioner, Quality & Program Improvement  
 M: 512-461-6263 ▪ [Andy.Vasquez@hhs.texas.gov](mailto:Andy.Vasquez@hhs.texas.gov) <— New  
 Links: [Quality Improvement](#) ▪ [Transformation Waiver](#) ▪ [P4Q](#) ▪ [LTC Quality](#) ▪ [QIPP](#)

-----Original Appointment-----

**From:** Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>  
**Sent:** Tuesday, July 20, 2021 10:46 AM  
**To:** Kristian, Diona (CMS/CMCS); Boston, Natasha (HHSC); Carter, Wrandi (HHSC); Gilmore, Fiona (HHSC); Hughes, Sheila (HHSC); Jung, Joelle (HHSC); Morcos, Betty (HHSC); Podgornoff, Dottie (HHSC); Quereau, Jennifer (HHSC); Quinn, Andrea (HHSC); Sentilles, Emily (HHSC); Tucker, Kimberly (HHSC); Tourk, Stephanie (HHSC); Luna, Beverly (HHSC); Vasquez, Andy (HHSC); Greenfield, Eli S. (CMS/CMCS); Devoid, Isaac (CMS/CMCS); Frankos-Rey, Andrew (CMS/CMCS); Khan, Rabia (CMS/CMCS); Garner, Angela D. (CMS/CMCS); Marunycz, Lisa (CMS/CMCS); Blunt, Ford J. (CMS/CMCS); Huynh, Linda (HHSC)  
**Subject:** Texas/CMS Meeting on DSRIP Flexibilities  
**When:** Thursday, August 12, 2021 2:00 PM-3:00 PM (UTC-05:00) Eastern Time (US & Canada).  
**Where:** <https://cms.zoomgov.com/j/1605214820?pwd=cVBldFdJNjdBNWV2eDhkOURhL0RyQT09>

FYI – the CMS meeting on DSRIP COVID accommodations was updated from Tuesday, August 3<sup>rd</sup> to Thursday, August 12<sup>th</sup>. Any previously forwarded meeting invite won't update in your calendar unless you emailed Diona a meeting accept. Please update your calendars accordingly. Thanks!

-----Original Appointment-----

**From:** Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>  
**Sent:** Tuesday, July 20, 2021 10:37 AM

**To:** Kristian, Diona (CMS/CMCS); Greenfield, Eli S. (CMS/CMCS); Devoid, Isaac (CMS/CMCS); Frankos-Rey, Andrew (CMS/CMCS); Khan, Rabia (CMS/CMCS); Garner, Angela D. (CMS/CMCS); Marunycz, Lisa (CMS/CMCS); Blunt, Ford J. (CMS/CMCS); Sentilles, Emily (HHSC); Huynh, Linda (HHSC)

**Cc:** Quereau, Jennifer (HHSC); Hughes, Sheila (HHSC); Vasquez, Andy (HHSC)

**Subject:** Texas/CMS Meeting on DSRIP Flexibilities

**When:** Thursday, August 12, 2021 2:00 PM-3:00 PM (UTC-05:00) Eastern Time (US & Canada).

**Where:** <https://cms.zoomgov.com/j/1605214820?pwd=cVBldFdJNjdBNWV2eDhkOURhLORyQT09>

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This meeting is a continuation of the discussion held on July 13.

Diona Kristian is inviting you to a scheduled ZoomGov meeting.

Join ZoomGov Meeting

<https://cms.zoomgov.com/j/1605214820?pwd=cVBldFdJNjdBNWV2eDhkOURhLORyQT09>

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Password: 453911

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## Summary of Impacts of COVID-19 on DSRIP

### Category B

Category B measures the patient population by provider (PPP) of the DSRIP performing provider's defined system. Each demonstration year (DY), performing providers must report the total number of individuals and the number of Medicaid Low-Income and Uninsured (MLIU) individuals served by its system. Providers are required to maintain or increase their MLIU PPP to receive full payment but are granted an allowable variation (between 1-5%) to account for normal fluctuations in their population. Providers are eligible for partial payment (50/75/90%) if they fall below their MLIU PPP numeric goal.

Approved COVID-19 reporting accommodations for DY9 included:

- Broadening the definition of an encounter to include patient telephone calls (for DY7-8, only face-to-face or virtual visits are allowed). A telephone call may be counted if it is the equivalent of a service that would be provided within the physical confines of the defined system.
- Adjusting the DY9 allowable variation in achievement of MLIU PPP goals. Under normal circumstances, providers were able to earn 100% payment if achievement fell within the 1-5% of their goal. Based on a study from Commonwealth Fund in the first half of 2020 and feedback from our stakeholders on the impact of the pandemic on utilization, the DY9 allowable variation was adjusted to 35%.

The table below shows the number of providers that reported per each achievement/payment bracket for DY7-9. The last two columns show how the providers performed with and without the approved flexibilities. The final column reflects the significant impact of COVID-19 on a provider's overall patient volume.

Payment Percent Achieved	DY7	DY8	DY9 with COVID AV (35%)	DY9 with Original AV
100%	251	238	281	157
90%	28	25	NA	45
75%	14	23	NA	68
50%	6	9	5	16
0%	1	5*	1	1
NMIs	NA	NA	3	3

\*DY8 0% achievement metrics were mainly providers who closed or withdrew from DSRIP

- Compared to their reported DY8 MLIU PPP volume, providers reported serving an average 96.1% of their DY8 MLIU PPP volume in DY9; total population served by the DSRIP providers decreased, even when accounting for the flexibility provided by the addition of telephone encounters. Thirty-nine of 290 participating providers specifically noted use of telehealth services during DY9 in their Category B qualitative reporting responses.
- Thirteen of 290 participating providers requested changes to their Category B system definitions and/or goals to help mitigate the impact of COVID-19 on their defined system. This is in addition to the DY9 reporting accommodations. Common requests were either to include in their system definition clinic sites that provided Covid-19 services (i.e. testing, vaccinations, etc or to reduce their MLIU PPP goal for DY9.

### Category C

DSRIP performing providers earn incentive payments by demonstrating annual improvements on their selected Category standardized quality measures. Providers establish their baseline performance with one calendar year of data for each measure. The measure goal for each program year is set as an improvement over the baseline. Each year, the percentage of improvement required to meet the goal increases. DSRIP performing providers specified their planned areas of improvement by selecting Category C Measure Bundles or measures from a menu based on their provider type. Each measure in the Measure Bundle Protocol is in a defined measure bundle, a grouping of measures that share a unified theme, apply to a similar population, and are impacted by similar activities, such as diabetes measures or hospital safety measures.

Approved COVID-19 reporting accommodations for DY9 included:

- Providers could earn payment for DY9 achievement milestones based on the higher of their approved DY8 achievement, the statewide average approved DY8 achievement per measure or measure bundle, or DY9 achievement in calendar year 2020.
- For measures that have been selected by 10 or fewer providers, the average approved DY8 achievement per bundle for measure was approved as the minimum payment for a provider's DY 9 achievement milestone.
- Providers were required to report CY 2020 data to be eligible for payment on the Category C DY9 achievement milestones.

### Category C Payments as a result of COVID Accommodations for CY2020

- Of the 3,228 achievement milestones (pay-for-performance) that were approved for Performance Year (PY) 3 (CY 2020) reporting in April 2021, 1,146 (or 36%) used accommodations to earn payments.
- Hospitals and LHDs used accommodations more than CMHCs and PPs.

Provider Type	% of Milestones Using Achievement Accommodations
CMHC	27%
Hospital	39%
LHD	36%
PP	28%



Volume Changes for Most Commonly Selected Category C Pay-for-Performance Measures that measure Medicaid and Low-Income Insured (MLIU)

- The most commonly reported measures for Category C saw an average decrease of 11.10% in the MLIU denominator population between Performance Year 2 (PY2) which is CY2019 and Performance Year 3 (PY3) which is CY2020.
- Measures for Cervical, Colorectal, and Breast Cancer screening saw the greatest decrease in patient volume impacting the denominator.
- While some measures reported an improvement in CY2020 rates as compared to CY2019, this must be considered alongside significant changes in volume. For example, while the measure C2-107 Colorectal Cancer Screening saw an increase of 7% in the median rate reported by DSRIP providers, the measures also saw a significant 20% decrease in denominator volume. This decrease in denominator volume makes it impossible to measure the actual impact of the COVID-19 pandemic on patient outcomes measured by DSRIP performing providers.

Measure ID	Measure Title	P4P Measures active DY7 - 10 reporting PY2 - PY3 Data	P4P MLIU PY2 Total Denominator	P4P MLIU PY3 Total Denominator	% Change in MLIU Denominator Volume CY2019 – CY2020	% Change in Median MLIU Rate Reported CY2019 - CY2020
A1-112	Comprehensive Diabetes Care: Foot Exam	72	128,392	107,167	-16.53%	-13.06%
A1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	72	130,450	110,694	-15.14%	-12.92%
A1-207	Diabetes care: BP control (<140/90mm Hg)	71	130,057	109,394	-15.89%	-4.82%
A2-103	Controlling High Blood Pressure	36	123,249	103,838	-15.75%	-11.93%
A2-210	Screening for High Blood Pressure and Follow-Up Documented	35	64,643	55,930	-13.48%	-2.33%
A2-404	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	34	76,301	70,910	-7.07%	1.70%
C1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	27	331,129	285,311	-13.84%	-0.01%
C1-113	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	30	61,385	55,096	-10.25%	-1.22%

Measure ID	Measure Title	P4P Measures active DY7-10 reporting PY2 - PY3 Data	P4P MLIU PY2 Total Denominator	P4P MLIU PY3 Total Denominator	% Change in MLIU Denominator Volume CY2019 – CY2020	% Change in Median MLIU Rate Reported CY2019 - CY2020
C1-147	Body Mass Index (BMI) Screening and Follow-Up	29	354,708	302,394	-14.75%	2.26%
C1-268	Pneumonia vaccination status for older adults	31	28,190	25,842	-8.33%	1.68%
C1-269	Preventive Care and Screening: Influenza Immunization	27	147,461	130,816	-11.29%	-13.83%
C1-272	Adults (18+ years) Immunization status	30	186,566	170,794	-8.45%	0.83%
C1-280	Chlamydia Screening in Women (CHL)	31	17,705	15,909	-10.14%	-1.01%
C1-389	Human Papillomavirus Vaccine (age 18 -26)	32	30,296	26,364	-12.98%	5.95%
C2-106	Cervical Cancer Screening	31	176,985	142,211	-19.65%	-1.47%
C2-107	Colorectal Cancer Screening	32	129,581	103,242	-20.33%	6.77%
C2-186	Breast Cancer Screening	33	95,747	76,661	-19.93%	-2.47%
K1-105	Rural: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	39	32,770	35,458	8.20%	1.74%
K1-268	Rural: Pneumonia vaccination status for older adults	40	5,246	5,272	0.50%	-7.54%
K1-285	Rural: Advance Care Plan	39	6,338	6,174	-2.59%	-27.69%
K2-287	Rural: Documentation of Current Medications in the Medical Record	21	66,972	62,619	-6.50%	-10.06%
K2-359	Rural: Emergency Transfer Communication Measure	24	4,954	4,770	-3.71%	-9.19%
M1-105	CMHC: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	31	138,479	121,850	-12.01%	-1.96%

Measure ID	Measure Title	P4P Measures active DY7-10 reporting PY2 - PY3 Data	P4P MLIU PY2 Total Denominator	P4P MLIU PY3 Total Denominator	% Change in MLIU Denominator Volume CY2019 – CY2020	% Change in Median MLIU Rate Reported CY2019 - CY2020
M11-147	CMHC: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	30	143,431	119,367	-16.78%	-5.53%

\*Most commonly selected MLIU measures, excluding data from providers that have not yet reported data for both PY2 and PY3

## Rate Changes for Most Commonly Selected Measures

- Of the most commonly selected MLIU measures, the majority of measures saw a decrease in performance in CY2020 as compared to prior years, in contrast to several years of increases in performance. Some measures that saw an increase in performance demonstrated a flattening off in improvement as compared to prior years trends, meaning the amount of improvement was smaller as compared to year over year improvement from prior years. Rate changes for the most commonly selected MLIU measures are illustrated in Appendix A.

Measure ID	Measure Title	Measure Class	Median MLIU Baseline (CY2017) Rate	Median MLIU PY1 (CY2018) Rate	Median MLIU PY2 (CY2019) Rate	Median MLIU PY3 (CY2020) Rate
A1-112	Comprehensive Diabetes Care: Foot Exam	Process	35.89%	49.24%	61.36%	53.35%
A1-115	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Clinical Outcome	37.29%	34.74%	31.61%	35.69%
A1-207	Diabetes care: BP control (<140/90mm Hg)	Clinical Outcome	63.91%	68.20%	70.04%	66.67%
A2-103	Controlling High Blood Pressure	Clinical Outcome	59.83%	62.22%	67.88%	59.78%
A2-210	Screening for High Blood Pressure and Follow-Up Documented	Process	46.17%	57.27%	58.09%	56.73%
A2-404	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Process	66.73%	73.71%	73.71%	74.97%
C1-105	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Process	76.49%	88.05%	92.92%	92.91%
C1-113	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	Process	82.69%	87.45%	89.58%	88.49%
C1-147	Body Mass Index (BMI) Screening and Follow-Up	Process	33.35%	63.08%	80.58%	82.40%
C1-268	Pneumonia vaccination status for older adults	Immunization	47.73%	64.24%	72.88%	74.10%
C1-269	Preventive Care and Screening: Influenza Immunization	Immunization	27.99%	36.29%	50.18%	43.24%
C1-272	Adults (18+ years) Immunization status	Immunization	2.32%	5.93%	13.47%	13.59%
C1-280	Chlamydia Screening in Women (CHL)	Process	37.16%	50.00%	56.61%	56.04%
C1-389	Human Papillomavirus Vaccine (age 18 -26)	Immunization	5.82%	12.16%	20.09%	21.29%
C2-106	Cervical Cancer Screening	Cancer Screening	43.94%	57.29%	63.74%	62.80%

Measure ID	Measure Title	Measure Class	Median MLIU Baseline (CY2017) Rate	Median MLIU PY1 (CY2018) Rate	Median MLIU PY2 (CY2019) Rate	Median MLIU PY3 (CY2020) Rate
C2-107	Colorectal Cancer Screening	Cancer Screening	36.13%	46.63%	50.31%	53.71%
C2-186	Breast Cancer Screening	Cancer Screening	54.52%	60.72%	65.33%	63.71%
K1-105	Rural: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Process	56.77%	73.71%	77.49%	78.85%
K1-268	Rural: Pneumonia vaccination status for older adults	Immunization	29.06%	40.00%	45.78%	42.32%
K1-285	Rural: Advance Care Plan	Process	11.24%	31.58%	37.68%	27.25%
K2-287	Rural: Documentation of Current Medications in the Medical Record	Process	66.14%	81.80%	83.21%	74.84%
K2-359	Rural: Emergency Transfer Communication Measure	Process	55.10%	62.79%	84.65%	76.87%
M1-105	CMHC: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Process	53.86%	79.92%	84.61%	82.95%
M1-147	CMHC: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Process	53.40%	79.50%	86.11%	81.35%

## Trends in Specific Populations

*Impact on Behavioral Health and Palliative Care Volume*

- Some measures were more likely to see an increase in denominator volume between CY2019 and CY2020, including measures related to depression diagnosis, psychiatric illness, and palliative care.
- While some hospitals reported a 46% increase in volume for psychiatric hospitalization as indicated by measure H2-160, they also saw an 81% improvement in the percentage of people receiving timely follow-up care likely due to changes in how follow-up care is delivered and measured during the pandemic. Specifically, follow-up care could be conducted via telemedicine including video and telephonic services, as opposed to requiring a face-to-face encounter.

Measure ID	Measure Title	P4P Measures active DY7-10 reporting PY2 - PY3 Data	P4P MLIU PY2 Total Denominator	P4P MLIU PY3 Total Denominator	% Difference PY3 from PY2 P4P MLIU Total Denominator	% Change in Median Rate CY2019 - CY2020
G1-278	Hospice Beliefs and Values Documentation	14	3,578	4,741	32.50%	-0.68%
G1-505	Proportion Admitted to Hospice for less than 3 days (PQRS #457)	1	33	40	21.21%	-3.13%
H2-160	Hospital: Follow-Up After Hospitalization for Mental Illness	5	2,453	3,582	46.03%	81.08%
M1-165	CMHC: Depression Remission at Twelve Months	4	2,682	5,231	95.04%	2.97%
M1-181	CMHC: Depression Response at Twelve Months- Progress Towards Remission	5	1,026	2,383	132.26%	36.64%
M1-211	CMHC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	12	12,768	14,574	14.14%	-10.49%
M1-255	CMHC: Follow-up Care for Children Prescribed ADHD Medication (ADD)	4	689	811	17.71%	28.47%
M1-286	CMHC: Depression Remission at Six Months	3	2,423	3,323	37.14%	33.46%
M1-287	CMHC: Documentation of Current Medications in the Medical Record	10	208,808	237,645	13.81%	-7.50%
M1-386	CMHC: Improvement in Functional Status or QoL (Modified from PQRS #435)	4	835	1,010	20.96%	-11.43%

*Impact on Pediatric Measures*

- Pediatric measures were more likely to see a decrease in denominator volume between CY2019 and CY2020. However, many pediatric measures saw an increase in denominator volume for the LIU population.
- Measures related to care of pediatric diabetes reveal an increase in the volume and a worsening in performance, which is in line with other recent observations of changes in rates of DKA among children with newly diagnoses Type 1 Diabetes during the COVID-19 pandemic.<sup>1</sup> The increase in admissions for pediatric diabetes complications is a stark contrast to the decrease in admissions for pediatric asthma during CY2020.

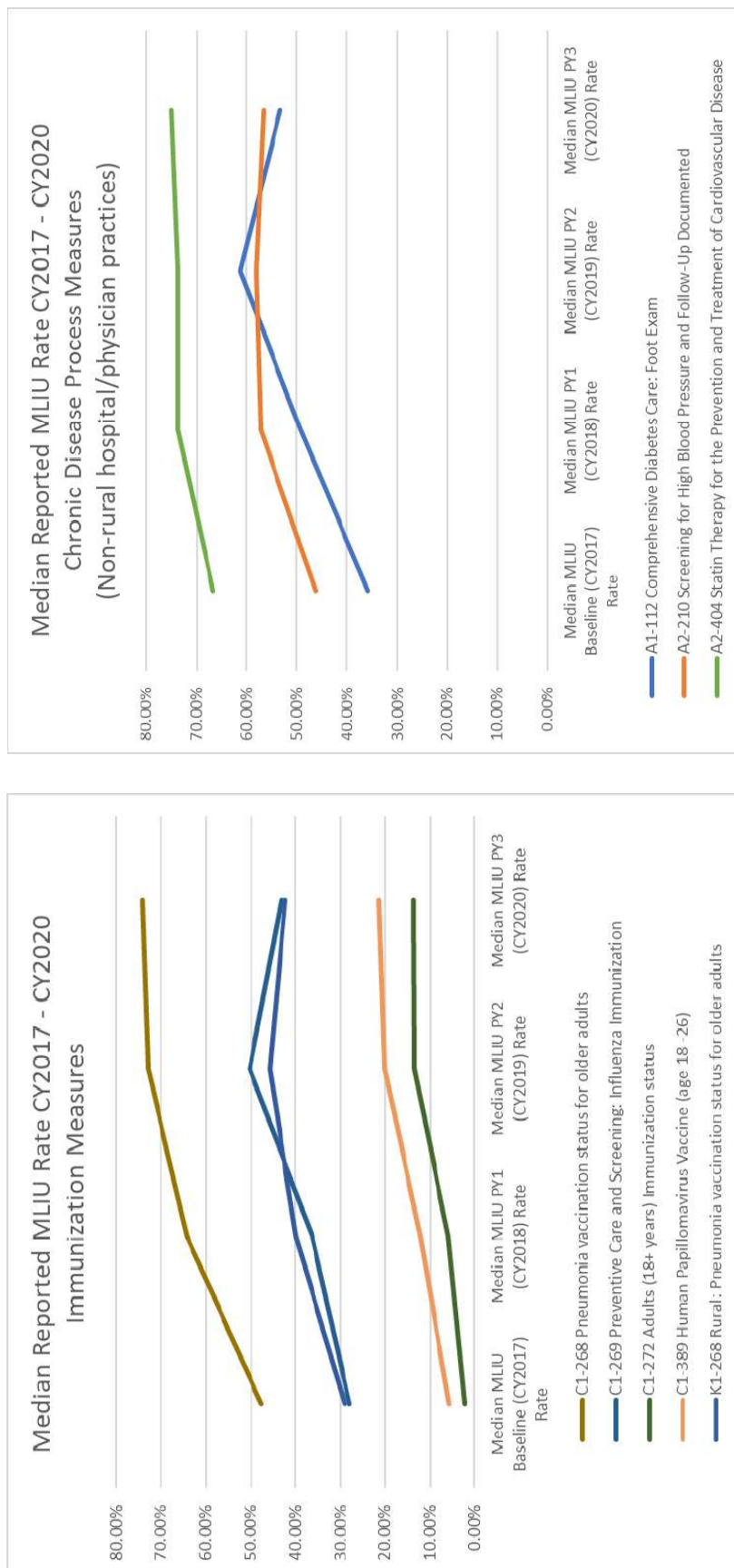
Measure ID	Measure Title	P4P Measures active DY7-10 reporting PY2 - PY3 Data	P4P MLIU PY2 Total Denominator	P4P MLIU PY3 Total Denominator	% Difference PY3 from PY2 P4P MLIU Total Denominator	% Change in Median Rate CY2019 - CY2020
D1-108	Childhood Immunization Status (CIS) (Age 2)	13	28,355	26,872	-5.23%	1.96%
D1-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	15	262,812	234,681	-10.70%	-2.42%
D1-212	Appropriate Testing for Children With Pharyngitis	15	37,813	16,037	-57.59%	-0.52%
D1-237	Well-Child Visits in the First 15 Months of Life (6 or more visits)	2	10,428	9,450	-9.38%	-15.35%
D1-271	Immunization for Adolescents (Age 13)	14	17,896	18,416	2.91%	-3.71%
D1-284	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	16	80,300	34,427	-57.13%	0.25%
D1-389	Human Papillomavirus Vaccine (age 15-18)	8	32,584	29,801	-8.54%	23.70%
D1-400	Tobacco Use and Help with Quitting Among Adolescents	16	144,688	129,517	-10.49%	-3.11%

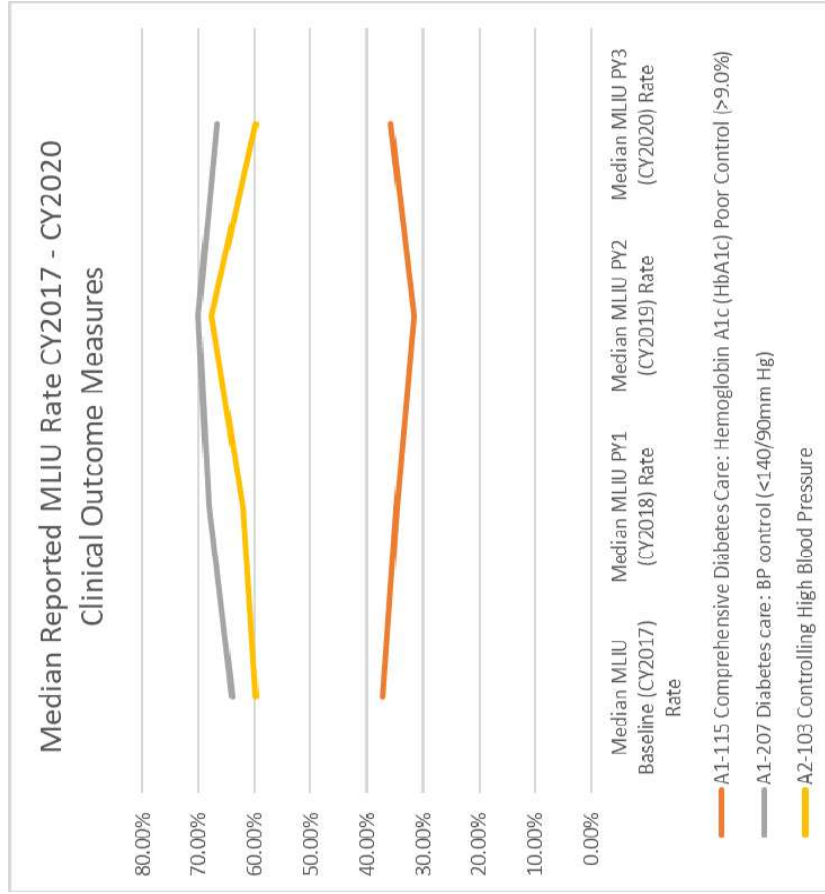
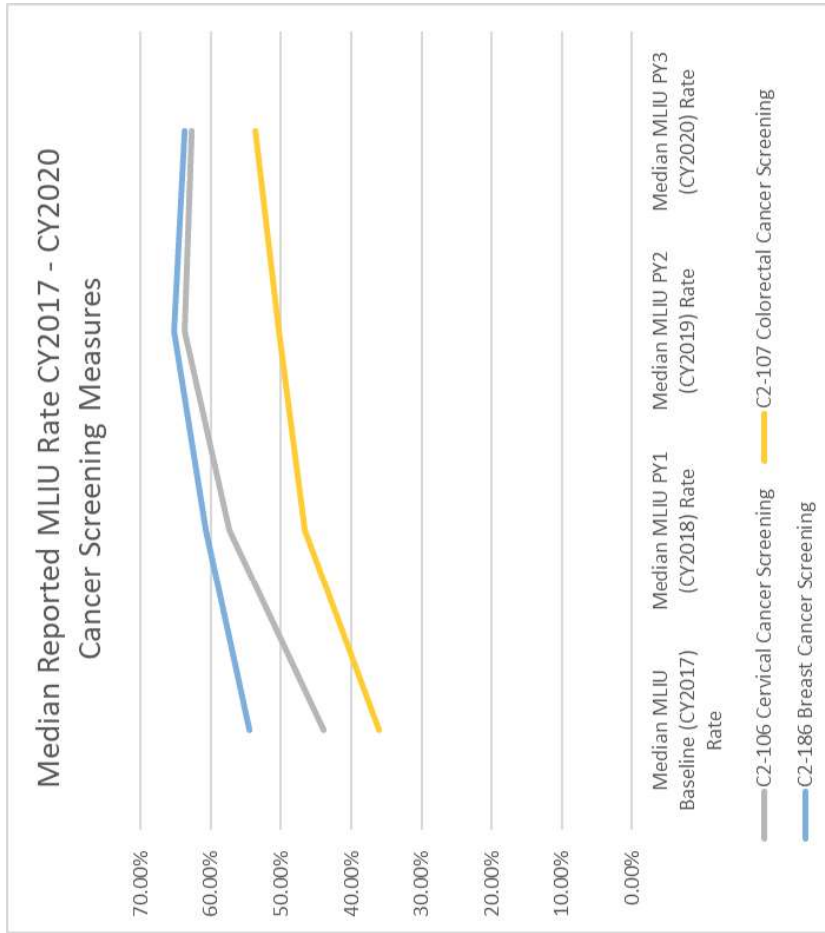
<sup>1</sup> <https://www.healio.com/news/endocrinology/20210422/severe-dka-at-type-1-diabetes-diagnosis-doubles-during-pandemic>

D1-503	PDI 91 Acute Composite (Gastroenteritis, Urinary Tract Infection Admission Rate)	10	523,971	427,682	-18.38%	42.26%
D4-139	Asthma Admission Rate (PDI14)	7	65,107	43,147	-33.73%	81.33%
D4-353	Proportion of Children with ED Visits for Asthma with Evidence of Primary Care Connection Before the ED Visit	5	3,790	2,448	-35.41%	-2.21%
D4-375	Asthma: Pharmacologic Therapy for Persistent Asthma (Rate 3 only)	7	8,559	6,632	-22.51%	-0.76%
D5-211	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	4	2,016	2,129	5.61%	-7.87%
D5-406	Diabetes Short-term Complications Admission Rate (PDI 15)	4	2,587	2,672	3.29%	-18.73%



Appendix A – Median Reported MLIU Rate C2017 – CY2020 for most selected Category C Measures of MLIU performance







**From:** [Stephens, Stephanie \(HHSC\)](#)  
**To:** [Kristian, Diona \(CMS/CMCS\)](#)  
**Cc:** [Young, Gary \(HHSC\)](#); [Hendrix, Kate \(HHSC\)](#); [Tourk, Stephanie \(HHSC\)](#); [Luna, Beverly \(HHSC\)](#); [Montalbano, Kathi \(HHSC\)](#); [Caruthers, Courtney \(HHSC\)](#); [Roland, Dawn \(HHSC\)](#); [Erwin, Michelle \(HHSC\)](#); [Ghasemi, Michael \(HHSC\)](#); [Grady, Victoria C. \(HHSC\)](#); [Butler, Rachel \(HHSC\)](#); [Wood, Trey \(HHSC\)](#); [Alletto, Michelle M. \(HHSC\)](#); [Bilse, Brittani \(HHSC\)](#); [Rashid, Mehreen \(CMS/CMCS\)](#); [DeCaro, Teresa \(CMS/CMCS\)](#); [Garner, Angela D. \(CMS/CMCS\)](#); [Marunycz, Lisa \(CMS/CMCS\)](#); [Greenfield, Eli S. \(CMS/CMCS\)](#); [Daly, Danielle N. \(CMS/CMCS\)](#); [Kazi, Paula \(CMS/CMCS\)](#); [Devoid, Isaac \(CMS/CMCS\)](#); [Blunt, Ford J. \(CMS/CMCS\)](#); [Heather Fleming](#)  
**Subject:** RE: Extension Application Complete Letter  
**Date:** Wednesday, July 28, 2021 5:07:59 PM

---

Thanks, Diona. We look forward to the next steps.

---

**From:** Kristian, Diona (CMS/CMCS) <Diona.Kristian@cms.hhs.gov>  
**Sent:** Wednesday, July 28, 2021 4:03 PM  
**To:** Stephens, Stephanie (HHSC) <Stephanie.Stephens01@hhs.texas.gov>  
**Cc:** Young, Gary (HHSC) <gary.young@hhs.texas.gov>; Hendrix, Kate (HHSC) <Kate.Hendrix@hhs.texas.gov>; Tourk, Stephanie (HHSC) <Stephanie.Tourk@hhs.texas.gov>; Luna, Beverly (HHSC) <Beverly.Luna@hhs.texas.gov>; Montalbano, Kathi (HHSC) <Kathi.Montalbano@hhs.texas.gov>; Caruthers, Courtney (HHSC) <Courtney.Caruthers@hhs.texas.gov>; Roland, Dawn (HHSC) <Dawn.Roland@hhs.texas.gov>; Erwin, Michelle (HHSC) <Michelle.Erwin@hhs.texas.gov>; Ghasemi, Michael (HHSC) <Michael.Ghasemi@hhs.texas.gov>; Grady, Victoria C. (HHSC) <Victoria.Grady@hhs.texas.gov>; Butler, Rachel (HHSC) <Rachel.Butler@hhs.texas.gov>; Wood, Trey (HHSC) <Trey.Wood@hhs.texas.gov>; Alletto, Michelle M. (HHSC) <Michelle.Alletto@hhs.texas.gov>; Bilse, Brittani (HHSC) <Brittani.Bilse@hhs.texas.gov>; Rashid, Mehreen (CMS/CMCS) <mehreen.rashid@cms.hhs.gov>; DeCaro, Teresa (CMS/CMCS) <teresa.decaro@cms.hhs.gov>; Garner, Angela D. (CMS/CMCS) <Angela.Garner@cms.hhs.gov>; Marunycz, Lisa (CMS/CMCS) <Lisa.Marunycz@cms.hhs.gov>; Greenfield, Eli S. (CMS/CMCS) <Eli.Greenfield@cms.hhs.gov>; Daly, Danielle N. (CMS/CMCS) <Danielle.Daly@cms.hhs.gov>; Kazi, Paula (CMS/CMCS) <Paula.Kazi@cms.hhs.gov>; Devoid, Isaac (CMS/CMCS) <Isaac.Devoid@cms.hhs.gov>; Blunt, Ford J. (CMS/CMCS) <Ford.Blunt@cms.hhs.gov>; Heather Fleming <heather.fleming@gov.texas.gov>; Kristian, Diona (CMS/CMCS) <Diona.Kristian@cms.hhs.gov>  
**Subject:** Extension Application Complete Letter

**WARNING:** This email is from outside the HHS system. Do not click on links or attachments unless you expect them from the sender and know the content is safe.

Dear Ms. Stephens,

Please find attached a letter notifying Texas that the state's extension application, submitted July 14, 2021 meets the requirements for a complete application. We will begin the federal public comment period process at this time, and reach out with next steps shortly.

Thank you,

Diona Kristian

**From:** [Bilse,Brittani \(HHSC\)](#)  
**To:** [Kristian, Diona \(CMS/CMCS\)](#); [Garner, Angela D. \(CMS/CMCS\)](#); [Boben, Paul J. \(CMS/CMCS\)](#); [Greenfield, Eli S. \(CMS/CMCS\)](#)  
**Cc:** [Young,Gary \(HHSC\)](#); [Montalbano,Kathi \(HHSC\)](#); [Marunycz, Lisa \(CMS/CMCS\)](#)  
**Subject:** RE: Texas Extension Application  
**Date:** Thursday, July 22, 2021 5:04:22 PM

---

Thank you. Ah yes...Please include:

Young,Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>;  
Hendrix,Kate (HHSC) <[Kate.Hendrix@hhs.texas.gov](mailto:Kate.Hendrix@hhs.texas.gov)>;  
Tourk,Stephanie (HHSC) <[Stephanie.Tourk@hhs.texas.gov](mailto:Stephanie.Tourk@hhs.texas.gov)>;  
Luna,Beverly (HHSC) <[Beverly.Luna@hhs.texas.gov](mailto:Beverly.Luna@hhs.texas.gov)>;  
Montalbano,Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>;  
Caruthers,Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>;  
Roland,Dawn (HHSC) <[Dawn.Roland@hhs.texas.gov](mailto:Dawn.Roland@hhs.texas.gov)>;  
Erwin,Michelle (HHSC) <[Michelle.Erwin@hhs.texas.gov](mailto:Michelle.Erwin@hhs.texas.gov)>;  
Ghasemi,Michael (HHSC) <[Michael.Ghasemi@hhs.texas.gov](mailto:Michael.Ghasemi@hhs.texas.gov)>;  
Grady,Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>;  
Butler,Rachel (HHSC) <[Rachel.Butler@hhs.texas.gov](mailto:Rachel.Butler@hhs.texas.gov)>;  
Wood,Trey (HHSC) <[Trey.Wood@hhs.texas.gov](mailto:Trey.Wood@hhs.texas.gov)>;  
Stephens,Stephanie (HHSC) <[Stephanie.Stephens01@hhs.texas.gov](mailto:Stephanie.Stephens01@hhs.texas.gov)>;  
Alletto,Michelle M (HHSC) [Michelle.Alletto@hhs.texas.gov](mailto:Michelle.Alletto@hhs.texas.gov)  
Brittani Bilse [Brittani.bilse@hhs.texas.gov](mailto:Brittani.bilse@hhs.texas.gov)

---

**From:** Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>  
**Sent:** Thursday, July 22, 2021 3:51 PM  
**To:** Bilse,Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>; Garner, Angela D. (CMS/CMCS) <[Angela.Garner@cms.hhs.gov](mailto:Angela.Garner@cms.hhs.gov)>; Boben, Paul J. (CMS/CMCS) <[Paul.Boben@cms.hhs.gov](mailto:Paul.Boben@cms.hhs.gov)>; Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>  
**Cc:** Young,Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>; Montalbano,Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Marunycz, Lisa (CMS/CMCS) <[Lisa.Marunycz@cms.hhs.gov](mailto:Lisa.Marunycz@cms.hhs.gov)>  
**Subject:** RE: Texas Extension Application

Brittani - Thanks, I can send out the invite. Please let me know who to include on the invite.  
Diona

---

**From:** Bilse,Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>  
**Sent:** Thursday, July 22, 2021 4:43 PM  
**To:** Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>; Garner, Angela D. (CMS/CMCS) <[Angela.Garner@cms.hhs.gov](mailto:Angela.Garner@cms.hhs.gov)>; Boben, Paul J. (CMS/CMCS) <[Paul.Boben@cms.hhs.gov](mailto:Paul.Boben@cms.hhs.gov)>; Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>  
**Cc:** Young,Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>; Montalbano,Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Marunycz, Lisa (CMS/CMCS) <[Lisa.Marunycz@cms.hhs.gov](mailto:Lisa.Marunycz@cms.hhs.gov)>  
**Subject:** RE: Texas Extension Application

Diona,

Yes. Texas is available to on Tuesday, July 27 at 3:00 ET/ 2:00 CT to provide an overview and answer questions. Attached is a slide deck containing the key features of the application.  
Let me know if you would like me to send out a calendar invite and host the call or if you all would like to.  
Thanks!  
Brittani

---

**From:** Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>  
**Sent:** Thursday, July 22, 2021 2:16 PM  
**To:** Bilse,Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>; Garner, Angela D. (CMS/CMCS) <[Angela.Garner@cms.hhs.gov](mailto:Angela.Garner@cms.hhs.gov)>; Boben, Paul J. (CMS/CMCS) <[Paul.Boben@cms.hhs.gov](mailto:Paul.Boben@cms.hhs.gov)>; Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>  
**Cc:** Young,Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>; Montalbano,Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Marunycz, Lisa (CMS/CMCS) <[Lisa.Marunycz@cms.hhs.gov](mailto:Lisa.Marunycz@cms.hhs.gov)>  
**Subject:** RE: Texas Extension Application

**WARNING:** This email is from outside the HHS system. Do not click on links or attachments unless you expect them from the sender and know the content is safe.

Hi Brittani,

Is Texas available on Tuesday, July 27 at 3:00 ET/ 2:00 CT to provide an overview of the application?

Diona

---

**From:** Bilse,Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>  
**Sent:** Friday, July 16, 2021 12:14 PM  
**To:** Garner, Angela D. (CMS/CMCS) <[Angela.Garner@cms.hhs.gov](mailto:Angela.Garner@cms.hhs.gov)>; Boben, Paul J. (CMS/CMCS) <[Paul.Boben@cms.hhs.gov](mailto:Paul.Boben@cms.hhs.gov)>; Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>; Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>  
**Cc:** Young,Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>; Montalbano,Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>  
**Subject:** Texas Extension Application

Good morning Team CMS,

As you know, the Executive Commissioner routed the 1115 THTQIP Extension application to the Secretary and CMS on Wednesday. We would like to provide an overview of the application next week in our monthly call. We also invite CMS to regular calls, every two weeks, in order to expedite reapproval and to address questions and concerns. There is a fiscal cliff looming for the Texas Medicaid program, so we humbly ask that CMS meet with us more frequently until approved.

Please let me know who I should work with in order to get this

scheduled.

Thanks!  
Brittani



**From:** [Bilse,Brittani \(HHSC\)](#)  
**To:** [Kristian, Diona \(CMS/CMCS\)](#); [Garner, Angela D. \(CMS/CMCS\)](#); [Boben, Paul J. \(CMS/CMCS\)](#); [Greenfield, Eli S. \(CMS/CMCS\)](#)  
**Cc:** [Young,Gary \(HHSC\)](#); [Montalbano,Kathi \(HHSC\)](#); [Marunycz, Lisa \(CMS/CMCS\)](#)  
**Subject:** RE: Texas Extension Application  
**Date:** Thursday, July 22, 2021 4:44:20 PM  
**Attachments:** [072021 Briefings on Extension Application.pdf](#)

---

Diona,

Yes. Texas is available to on Tuesday, July 27 at 3:00 ET/ 2:00 CT to provide an overview and answer questions. Attached is a slide deck containing the key features of the application.

Let me know if you would like me to send out a calendar invite and host the call or if you all would like to.

Thanks!

Brittani

---

**From:** Kristian, Diona (CMS/CMCS) <Diona.Kristian@cms.hhs.gov>  
**Sent:** Thursday, July 22, 2021 2:16 PM  
**To:** Bilse,Brittani (HHSC) <Brittani.Bilse@hhs.texas.gov>; Garner, Angela D. (CMS/CMCS) <Angela.Garner@cms.hhs.gov>; Boben, Paul J. (CMS/CMCS) <Paul.Boben@cms.hhs.gov>; Greenfield, Eli S. (CMS/CMCS) <Eli.Greenfield@cms.hhs.gov>  
**Cc:** Young,Gary (HHSC) <gary.young@hhs.texas.gov>; Montalbano,Kathi (HHSC) <Kathi.Montalbano@hhs.texas.gov>; Marunycz, Lisa (CMS/CMCS) <Lisa.Marunycz@cms.hhs.gov>  
**Subject:** RE: Texas Extension Application

**WARNING:** This email is from outside the HHS system. Do not click on links or attachments unless you expect them from the sender and know the content is safe.

Hi Brittani,

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---

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**Sent:** Friday, July 16, 2021 12:14 PM  
**To:** Garner, Angela D. (CMS/CMCS) <[Angela.Garner@cms.hhs.gov](mailto:Angela.Garner@cms.hhs.gov)>; Boben, Paul J. (CMS/CMCS) <[Paul.Boben@cms.hhs.gov](mailto:Paul.Boben@cms.hhs.gov)>; Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>; Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>  
**Cc:** Young,Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>; Montalbano,Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>  
**Subject:** Texas Extension Application

Good morning Team CMS,

As you know, the Executive Commissioner routed the 1115 THTQIP



Extension application to the Secretary and CMS on Wednesday. We would like to provide an overview of the application next week in our monthly call. We also invite CMS to regular calls, every two weeks, in order to expedite reapproval and to address questions and concerns. There is a fiscal cliff looming for the Texas Medicaid program, so we humbly ask that CMS meet with us more frequently until approved.

Please let me know who I should work with in order to get this scheduled.

Thanks!  
Brittani



# 1115 Waiver

## Texas Healthcare Transformation and Quality Improvement Program

# July 2021 Extension

## Texas requested an extension.

- Texas submitted an extension application to CMS on July 14, 2021.
- The extension requested the same terms and conditions as approved by CMS on January 15, 2021.
- To the extent re-approval is necessary, the extension requested CMS re-approve these terms by September 30, 2021.



TEXAS  
Health and Human  
Services

# Maintain Continuity

- Texas Medicaid has a mature 1115 waiver inclusive of:
  - **17** Medicaid Managed Care Organizations
  - **288** Performing providers in Delivery System Reform Incentive Program (DSRIP)
  - **864** Nursing facilities in Quality Incentive Payment Program (QIPP)
  - **529** Providers in the Uncompensated Care Program
  - **3** Dental Maintenance Organizations
- HHSC will continue to advance the goals of the waiver under this extension and align new programs with overall Medicaid



TEXAS  
Health and Human  
Services

# Requested Programs

- **Comprehensive Hospital Increased Reimbursement Program (CHIRP)**  
\$5,020,000,000
- **Quality Incentive Payment Program (QIPP)**  
\$1,100,000,000
- **Texas Incentives for Physicians and Professional Services (TIPPS)** \$600,000,000
- **Rural Access Primary and Preventive Services (RAPPS)** \$18,700,000
- **Ambulance Average Commercial Reimbursement Program** \$150,000,000
- **DPP for Behavioral Health Services (DPP BHS)**  
\$165,575,152



**TEXAS**  
Health and Human  
Services

# Public Health Providers

## Extension creates the Public Health Provider-Charity Care Program (PHP-CCP)

- Begins on October 1, 2021/End of DSRIP
- Offsets costs associated with care, including behavioral health, immunizations, chronic disease prevention and other preventive services for the uninsured
- Public providers only
- Financed by certified public expenditures
- Year 1 & 2 will be up to \$500 million



**TEXAS**  
Health and Human  
Services

# Uncompensated Care Pool Resizing

## The UC Pool will be resized twice

- First re-sizing will take place in DY11 to take effect in DY12 (FY2023)
  - In recognition that the PHE will impact FY20 and FY21 cost report data, re-sizing will use the 2019 cost reports and the 2017 DSH payment data
- Second re-sizing will take place in DY16 to take effect in DY17 (FY2028)
  - Sizing will use the 2025 cost reports and 2023 DSH payment data
- Re-sizing will allow for adjustments to uncompensated care pool based on actual charity care



# Budget Neutrality

## Key Principles

- Extension preserves budget neutrality and creates room for DSRIP transition, including directed payment and charity care programs
- Without Waiver expenditures will be rebased and include directed payment program funding
- Adjustment for COVID-19 impact on enrollment and expenditures



TEXAS  
Health and Human  
Services



# Budget Neutrality

---

## Key Principles (cont.)

- DSRIP Transition Programs and Public Health Provider funding is sustainable
- Extension achieves an estimated \$10 billion in vital budget neutrality



TEXAS  
Health and Human  
Services

# Monitoring & Reporting

## New STCs emphasize importance of monitoring and reporting

- COVID-19 disrupted data collection
- Terms negotiated with CMS
  - Emphasize the responsibility of the state to provide oversight of funds
  - Require additional reporting on sources of funds
  - Require new Home and Community Based Services (HCBS) reporting
  - Require a new HCBS Quality Assurance Report
  - Require more frequent monitoring reports



TEXAS  
Health and Human  
Services

# External Evaluation

## New Evaluation Design for the Extension

- **Purpose:** Provide insight into whether the state is progressing on the overarching goals of the Demonstration
- **Main components:**
  - Medicaid Managed Care
  - Directed Payment Programs
  - Supplemental Payment Pools
    - Uncompensated Care
    - Public Health Providers Charity Care
  - Cost outcomes for the demonstration as a whole

Texas v. Brooks-LaSure, No. 21-cv-191  
A.R. 010



TEXAS  
Health and Human  
Services

# External Evaluation

---

## New Evaluation Design for the Extension (cont.)

- **Three Interim Evaluation Reports:**
  - March 2024
  - March 2027
  - September 2029
- **One Summative Evaluation Report:**
  - March 2032



**TEXAS**  
Health and Human  
Services

# Waiver Extension

- Potential of \$11.4 billion per year on average
  - Includes \$3.9 billion per year for payments for uncompensated care
  - Includes \$500 million per year for payments for new Public Health Provider-Charity Care Program
  - Includes opportunity for \$6.9 billion per year for quality and access improvements
- Saves an estimated \$10 billion in taxpayer funds over the life of the waiver



**TEXAS**  
Health and Human  
Services

**From:** [Bilse,Brittani \(HHSC\)](#)  
**To:** [Kristian, Diona \(CMS/CMCS\)](#); [HHSC TX Medicaid Waivers](#); [Greenfield, Eli S. \(CMS/CMCS\)](#); [Blunt, Ford J. \(CMS/CMCS\)](#)  
**Cc:** [Montalbano,Kathi \(HHSC\)](#); [Young,Gary \(HHSC\)](#); [Roland,Dawn \(HHSC\)](#)  
**Subject:** RE: Agenda Items for CMS Call  
**Date:** Thursday, July 22, 2021 11:59:37 AM  
**Attachments:** [image001.png](#)

---

Diona,  
Good morning.

Yes. That works. We will work to make ourselves available as soon as possible for you and your team. Dawn may have already sent the slide deck up. If not, we can go ahead and get that to you if that is helpful.

Thank you!

Brittani

---

**From:** Kristian, Diona (CMS/CMCS) <Diona.Kristian@cms.hhs.gov>  
**Sent:** Thursday, July 22, 2021 10:56 AM  
**To:** HHSC TX Medicaid Waivers <TX\_Medicaid\_Waivers@hhs.texas.gov>; Greenfield, Eli S. (CMS/CMCS) <Eli.Greenfield@cms.hhs.gov>; Blunt, Ford J. (CMS/CMCS) <Ford.Blunt@cms.hhs.gov>  
**Cc:** Montalbano,Kathi (HHSC) <Kathi.Montalbano@hhs.texas.gov>; Young,Gary (HHSC) <gary.young@hhs.texas.gov>; Bilse,Brittani (HHSC) <Brittani.Bilse@hhs.texas.gov>; Roland,Dawn (HHSC) <Dawn.Roland@hhs.texas.gov>  
**Subject:** RE: Agenda Items for CMS Call

**WARNING:** This email is from outside the HHS system. Do not click on links or attachments unless you expect them from the sender and know the content is safe.

Hello,

We are removing the overview from today's agenda. We are going to schedule a separate kick-off call for the 1115 Extension Application.

Brittani – Should I work with you on setting up the kick-off call?

Diona

---

**From:** HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>  
**Sent:** Tuesday, July 20, 2021 12:57 PM  
**To:** Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>; Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>; Blunt, Ford J. (CMS/CMCS) <[Ford.Blunt@cms.hhs.gov](mailto:Ford.Blunt@cms.hhs.gov)>  
**Cc:** Montalbano,Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Young,Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>; Bilse,Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>; Roland,Dawn (HHSC) <[Dawn.Roland@hhs.texas.gov](mailto:Dawn.Roland@hhs.texas.gov)>  
**Subject:** Agenda Items for CMS Call

Good morning,

Here are the agenda items HHSC would like to discuss during Thursday's monthly call.

Agenda Items:

1. 2021 Legislative Overview
2. 1115 Extension Application Overview
3. Evaluation Design Overview

Please let us know if CMS has any agenda items for Texas.

Thank you.

Sincerely,

*Dawn M. Roland*

Dawn M. Roland, B.S.ED., CMP, CWM  
1915(c), 1915(b), 1915(i) Waivers Program Specialist II  
Policy Development Support  
Medicaid/CHIP Services  
**Texas Health and Human Services Commission**  
[Dawn.Roland@hhs.texas.gov](mailto:Dawn.Roland@hhs.texas.gov)



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**From:** [HHSC TX Medicaid Waivers](#)  
**To:** [Greenfield, Eli S. \(CMS/CMCS\)](#); [Kristian, Diona \(CMS/CMCS\)](#); [Blunt, Ford J. \(CMS/CMCS\)](#)  
**Cc:** [Montalbano, Kathi \(HHSC\)](#); [Young, Gary \(HHSC\)](#); [Bilse, Brittani \(HHSC\)](#); [Roland, Dawn \(HHSC\)](#)  
**Subject:** Agenda Items for CMS Call  
**Date:** Tuesday, July 20, 2021 12:58:17 PM  
**Attachments:** [image001.png](#)

---

Good morning,

Here are the agenda items HHSC would like to discuss during Thursday's monthly call.

Agenda Items:

1. 2021 Legislative Overview
2. 1115 Extension Application Overview
3. Evaluation Design Overview

Please let us know if CMS has any agenda items for Texas.

Thank you.

Sincerely,

*Dawn M. Roland*

Dawn M. Roland, B.S.ED., CMP, CWM  
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**From:** [Bilse,Brittani \(HHSC\)](#)  
**To:** [Garner, Angela D. \(CMS/CMCS\)](#); [Boben, Paul J. \(CMS/CMCS\)](#); [Greenfield, Eli S. \(CMS/CMCS\)](#); [Kristian, Diona \(CMS/CMCS\)](#)  
**Cc:** [Young,Gary \(HHSC\)](#); [Montalbano,Kathi \(HHSC\)](#)  
**Subject:** Texas Extension Application  
**Date:** Friday, July 16, 2021 12:15:50 PM

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Good morning Team CMS,

As you know, the Executive Commissioner routed the 1115 THTQIP Extension application to the Secretary and CMS on Wednesday. We would like to provide an overview of the application next week in our monthly call. We also invite CMS to regular calls, every two weeks, in order to expedite reapproval and to address questions and concerns. There is a fiscal cliff looming for the Texas Medicaid program, so we humbly ask that CMS meet with us more frequently until approved.

Please let me know who I should work with in order to get this scheduled.

Thanks!  
Brittani

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**Subject:** Evaluation Design  
**Date:** Wednesday, July 14, 2021 5:39:34 PM  
**Attachments:** [1115 Extension Evaluation Design 07.14.21 final.docx](#)  
[1115 Extension Evaluation Design 07.14.21 FINAL.pdf](#)

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Good afternoon Diona,

In accordance with the Texas Healthcare Transformation Quality Improvement Program (THTQIP) waiver approved on January 15, 2021 under section 1115 of the Social Security Act, Special Terms and Conditions 82, the Texas Health and Human Services Commission submits to the Centers for Medicare and Medicaid Services (CMS) the following documents related to the Attachment S: Evaluation Design.

A pdf and word version of the evaluation design document

Thanks.



# **Texas Healthcare Transformation and Quality Improvement Program Demonstration Waiver Evaluation Design Plan**

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**As Required by  
Centers for Medicare and Medicaid  
Services**

**Texas Health and Human Services**

**Commission**

**Office of Data, Analytics, and**

**Performance**

**July 14, 2021**



**TEXAS**  
Health and Human  
Services

# Table of Contents

<b>Table of Contents .....</b>	<b>1</b>
<b>List of Figures .....</b>	<b>2</b>
<b>List of Tables.....</b>	<b>2</b>
<b>1. Background and Introduction .....</b>	<b>3</b>
Medicaid in Texas.....	3
History of the Texas 1115 Demonstration .....	3
Focus of the Evaluation .....	14
<b>2. Evaluation Questions and Hypotheses .....</b>	<b>15</b>
Logic Model .....	16
Evaluation Questions .....	18
<b>3. Methodology.....</b>	<b>21</b>
MMC Evaluation Methods.....	21
DPP Evaluation Methods .....	35
SPP Evaluation Methods .....	47
Overall Demonstration Evaluation Methods .....	57
<b>4. Special Methodological Considerations.....</b>	<b>65</b>
<b>5. Communication, Dissemination, and Reporting .....</b>	<b>67</b>
<b>Appendix A. Document History Log .....</b>	<b>69</b>
<b>Appendix B. Independent Evaluator .....</b>	<b>70</b>
<b>Appendix C. HHSC Quality Initiative Descriptions .....</b>	<b>74</b>
<b>Appendix D. DPP Descriptions.....</b>	<b>77</b>
<b>Appendix E. Detailed Tables .....</b>	<b>79</b>
<b>Appendix F. List of Acronyms .....</b>	<b>170</b>
<b>Appendix G. References .....</b>	<b>173</b>

## **List of Figures**

Figure 1. Demonstration Overview .....	6
Figure 2. Texas MMC Growth Over Time.....	9
Figure 3. Demonstration Logic Model .....	17
Figure 4. Study Periods for DPP Evaluation Component .....	42
Figure 5. SPP Timeline.....	51
Figure 6. Estimated Evaluation Timeline and Major Milestones.....	72

## **List of Tables**

Table 1. Texas 1115 Demonstration Key Dates .....	4
Table 2. Texas Directed Payment Programs Included in Evaluation.....	12
Table 3. Demonstration Alignment .....	15
Table 4. Evaluation Design Overview, Evaluation Question 1 .....	23
Table 5. Evaluation Design Overview, Evaluation Question 2 .....	24
Table 6. Evaluation Design Overview, Evaluation Question 3 .....	26
Table 7. Study Periods for the MMC Evaluation Component.....	29
Table 8. Evaluation Design Overview, Evaluation Question 4 .....	36
Table 9. Evaluation Design Overview, Evaluation Question 5 .....	37
Table 10. DPP Study Populations.....	40
Table 11. Evaluation Design Overview, Evaluation Question 6 .....	48
Table 12. Evaluation Design Overview, Evaluation Question 7 .....	49
Table 13. UC Program Providers (DY9).....	50
Table 14. Study Periods for SPP Evaluation Component.....	51
Table 15. Evaluation Design Overview, Evaluation Question 8 .....	58
Table 16. Evaluation Design Overview, Evaluation Question 9 .....	58
Table 17. Evaluation Design Overview, Evaluation Question 10.....	59
Table 18. Schedule of Evaluation Deliverables.....	68
Table 19. Document History Log .....	69
Table 20. Proposed Evaluation Budget .....	71

# 1. Background and Introduction

## Medicaid in Texas

Texas has the second largest population in the United States and operates the third largest Medicaid program in the country (Centers for Medicare and Medicaid Services, 2020). In State Fiscal Year (SFY) 2019, the Texas Health and Human Services Commission (HHSC) provided Medicaid benefits to approximately 4.3 million people (Texas Health and Human Services Commission, 2020). That same year, the Texas Medicaid program cost the state and federal governments a combined total of approximately \$65 billion, accounting for 27 percent of the state budget (Texas Health and Human Services Commission, 2020). As the Texas population continues to grow, the number of individuals eligible for Medicaid is projected to increase.

One of the most significant issues facing the Texas Medicaid program is coordination of the healthcare system—specifically, how to provide coordinated, high quality services while containing costs. A lack of care coordination can lead to less effective use of care, resulting in increased costs for a program that already represents over one-quarter of the state’s annual budget. Given the scope and importance of the Medicaid program in providing care to low-income Texans, it is vital to maximize efficiency and stabilize system funding while supporting cost-effective access, coordination, and quality of care.

## History of the Texas 1115 Demonstration

The 82<sup>nd</sup> Texas Legislature, 2011, directed HHSC to expand Medicaid managed care (MMC) statewide and preserve supplemental payments for hospitals (Texas Health and Human Services Commission, 2020). In response to these directives, HHSC applied for an 1115 demonstration waiver titled the “Texas Healthcare Transformation and Quality Improvement Program” (Demonstration) and received approval from the Centers for Medicare and Medicaid Services (CMS) for a five-year Demonstration in December 2011. The goals of the initial Demonstration were to:

- Expand risk-based managed care to new populations and services.
- Support the development and maintenance of a coordinated care delivery system.
- Improve outcomes while containing cost growth.
- Transition to quality-based payment systems across managed care and providers.

The Demonstration has been renewed and extended several times since its original approval. Table 1 shows the key dates of the Demonstration.

**Table 1. Texas 1115 Demonstration Key Dates**

<b>Description</b>	<b>Approval Date</b>	<b>Demonstration Authorized Through</b>
<b>Initial Approval</b>	December 12, 2011	September 30, 2016
<b>15-Month Extension</b>	May 1, 2016	December 31, 2017
<b>Renewal</b>	December 21, 2017	September 30, 2022
<b>Ten-Year Extension</b>	January 15, 2021	September 30, 2030

### **Focus of the Demonstration Extension**

From 2011 to 2021, the Demonstration included three components: MMC expansion, the Delivery System Reform Incentive Payment (DSRIP) pool, and the Uncompensated Care (UC) pool. Together, these components played a critical role in transforming the state healthcare system over the life of the Demonstration. The three components improved care delivery and the efficient use of Medicaid funds through MMC expansion, created a broad-scale effort to drive quality improvement and incentivize provider innovation under the DSRIP program, and established critical financial supports for Medicaid providers through the UC pool.

While the state has made significant progress towards the goals set forth in the initial Demonstration, the objectives of the Demonstration remain ongoing priorities that continue to guide state efforts in the Medicaid program. The Demonstration Extension (Extension) approved on January 15, 2021 allows Texas continued flexibility to pursue these goals. Specific aims of the Extension include transitioning additional services to MMC while improving the overall quality of the MMC service delivery model, promoting access to care and value-based incentives achieved under DSRIP, and sustaining the financial stability of Medicaid providers.

To meet these aims, the Extension will make significant changes to previous Demonstration components, including:

- The expiration of the DSRIP pool on September 30, 2021 and the implementation of four new Directed Payment Programs (DPPs) on September 1, 2021.<sup>1</sup> The DPPs require CMS approval annually. The first year of implementation is projected to end August 31, 2022. However, HHSC plans to extend the DPPs for additional demonstration years.
- The implementation of a new supplemental payment program (SPP), titled the Public Health Provider Charity Care Pool (PHP-CCP) program, on October 1, 2021.

The Extension will facilitate MMC expansion for additional services and populations and will continue the UC pool. Figure 1 below depicts the key demonstration components over time.

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<sup>1</sup> Implementation of new DPPs is pursuant to 438.6(c) requiring CMS approval.

MMC, DPPs, and two SPPs comprise the three main components of the Extension:

- Medicaid Managed Care
- Directed Payment Programs<sup>2</sup>
  - ▶ Comprehensive Hospital Increased Reimbursement Program (CHIRP)
  - ▶ Directed Payment Program for Behavioral Health Services (DPP BHS)
  - ▶ Rural Access to Primary and Preventative Services (RAPPS)
  - ▶ Texas Incentives for Physician and Professional Services (TIPPS)
  - ▶ Quality Incentive Payment Program (QIPP)
- Supplemental Payment Programs
  - ▶ Uncompensated Care Program<sup>3</sup>
  - ▶ Public Health Provider Charity Care Pool Program

Additional details on components included in the Extension, as well as evaluation implications, are provided in subsequent sections.

---

<sup>2</sup> This evaluation focuses on five DPPs: four new DPPs (CHIRP, DPP BHS, RAPPS, and TIPPS), and one existing DPP (QIPP). This is not an exhaustive list of all DPPs in Texas, only those developed through the DSRIP transition plan and/or those tied to a specific managed care quality strategy.

<sup>3</sup> The UC Pool transitioned to charity care only in DY9.



**Figure 1. Demonstration Overview**

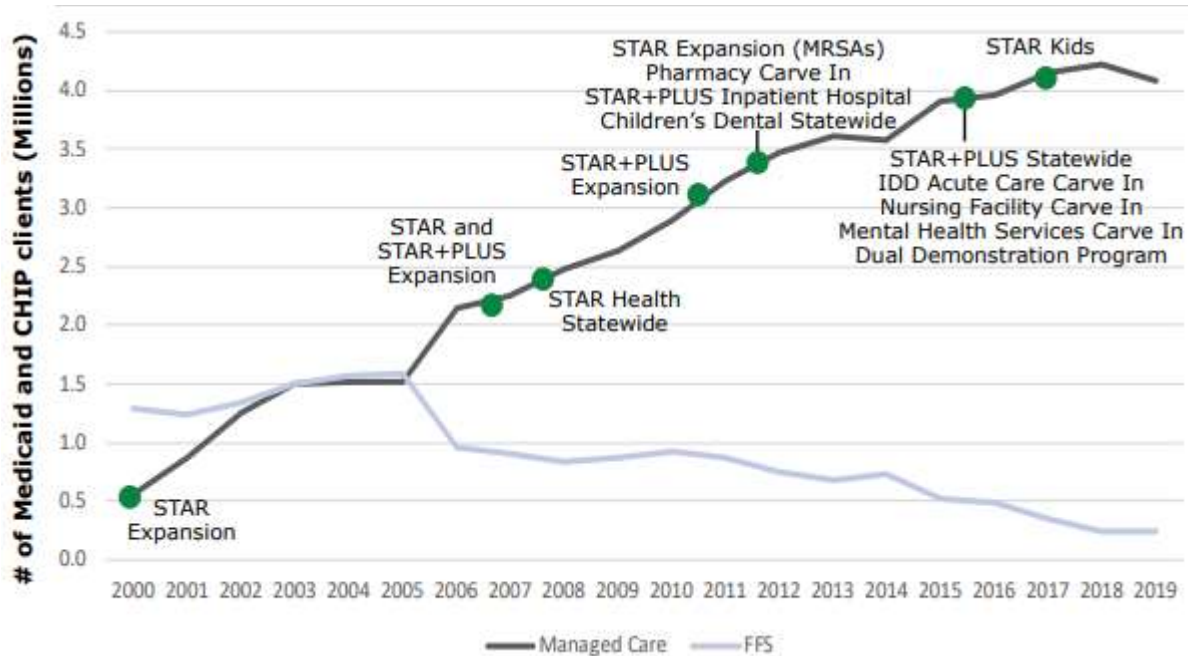
Demonstration Component	Initial Demonstration Period 5 Years: December 2011-September 2016					15-Month Extension	Demonstration Renewal Period 3 Years: January 2018-January 2021 <sup>1</sup>					Demonstration Extension Period 10 Years: January 2021-September 2030									
MMC <sup>2</sup>	DY1	DY2	DY3	DY4	DY5	DY6	DY7	DY8	DY9	DY10	DY11	DY12	DY13	DY14	DY15	DY16	DY17	DY18	DY19		
	FFY 2012	FFY 2013	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019	FFY 2020	FFY 2021	FFY 2022	FFY 2023	FFY 2024	FFY 2025	FFY 2026	FFY 2027	FFY 2028	FFY 2029	FFY 2030		
	PCCM ended STAR statewide expansion STAR+PLUS expansion to Hidalgo & Lubbock SDAs																				
	STAR+PLUS statewide expansion																				
	Additional populations and benefits carved into MMC from DY1 to DY10 <sup>3</sup>																				
DSRIP	FFY 2012	FFY 2013	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019	FFY 2020	FFY 2021	FFY 2022	FFY 2023	FFY 2024	FFY 2025	FFY 2026	FFY 2027	FFY 2028	FFY 2029	FFY 2030		
	Project development and planning																				
	Projects implemented																				
DPPs <sup>4</sup>	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	SFY 2026	SFY 2027	SFY 2028	SFY 2029	SFY 2030		
	QIPP implemented																				
	UHRIP Implemented																				
UC	FFY 2012	FFY 2013	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019	FFY 2020	FFY 2021	FFY 2022	FFY 2023	FFY 2024	FFY 2025	FFY 2026	FFY 2027	FFY 2028	FFY 2029	FFY 2030		
	UPL program ended New UC reporting tool implemented: Focus shifted from																				
	claims for UC charges to UC costs																				
PHP-CCP	FFY 2012	FFY 2013	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019	FFY 2020	FFY 2021	FFY 2022	FFY 2023	FFY 2024	FFY 2025	FFY 2026	FFY 2027	FFY 2028	FFY 2029	FFY 2030		

Notes. <sup>1</sup> The Demonstration Renewal Period was originally approved for five years through September 2022, however the Renewal Period ended upon approval of the Extension on January 15, 2021. <sup>2</sup> MMC section only includes expansion activities included in the evaluation at the time of writing. This figure will be updated, as necessary, to reflect future changes to MMC. <sup>3</sup> Additional populations and services Texas carved into MMC during the first 10 years of the Demonstration include pharmacy benefits, non-behavioral health inpatient hospital stays, children's dental services, nursing facility services, mental health targeted case management and rehabilitative services, acute care for individuals with intellectual and developmental disabilities, adoption assistance, permanency care assistance, and the Medicaid for Breast and Cervical Cancer program. <sup>4</sup> Implementation periods for DPPs reflect approval periods at the time of writing this evaluation design. HHSC plans to extend implementation of QIPP, CHIRP, DPP BHS, RAPPs, and TIPPs for additional demonstration years.

DY= Demonstration year, October 1-September 30; MMC=Medicaid managed care; FFY=Federal fiscal year, October 1-September 30; PCCM=Primary care case management; STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; SDA=Service delivery area; FFS=Fee-for-service; STAR Kids=MMC program serving disabled individuals 20 years and younger; NEMT=Non-emergency medical transport; DRTS=Demand response transportation services; TNC=Transportation network company; STAR+PLUS HCBS=STAR+PLUS Home and Community-Based Services; CMS=Centers for Medicare and Medicaid; LTSS=Long-term services and supports; IDD=Intellectual or developmental disability; DSRIP=Delivery System Reform Incentive Payment; DPP=Directed payment program; SFY=State fiscal year, September 1-August 31; QIPP=Quality Incentive Payment Program; UHRIP=Uniform Hospital Rate Increase Program; CHIRP=Comprehensive Hospital Increased Reimbursement Program; DPP BHS=Directed Payment Program for Behavioral Health Services; RAPPs=Rural Access to Primary and Preventive Services; TIPPs=Texas Incentives for Physician and Professional Services; UC=Uncompensated Care; UPL=Upper payment limit; PHP-CCP=Public Health Provider Charity Care Pool.

## Medicaid Managed Care

Texas has operated various MMC programs since 1993, beginning with the implementation of STAR in Travis, Chambers, Jefferson, and Galveston counties. Since that time, Texas has vastly expanded its managed care delivery system, with the majority of these changes occurring under the Demonstration. Beginning in federal fiscal year (FFY) 2012, three changes to Texas Medicaid programs were implemented as part of the Demonstration: (1) the primary care case management health care delivery model ended; (2) the STAR MMC program, which provides coverage primarily to children and pregnant women, expanded statewide; and (3) the STAR+PLUS MMC program, which provides services to older adults and people with disabilities, expanded to two new service areas. As the Demonstration evolved, Texas expanded STAR+PLUS statewide and incorporated new services and populations into STAR+PLUS. Texas also implemented a new MMC program, STAR Kids, to provide services to children and young adults with disabilities. Additionally, Texas carved in new populations and services from traditional fee-for-service (FFS) into MMC programs over the course of the Demonstration. For example, pharmacy benefits, non-behavioral health inpatient hospital stays, children's dental services, nursing facility services, mental health targeted case management and rehabilitative services, acute care for individuals with intellectual and developmental disabilities, adoption assistance, permanency care assistance, and the Medicaid for Breast and Cervical Cancer program have all been carved into MMC under the Demonstration. HHSC has also been granted a series of amendments to make the MMC service delivery model easier for beneficiaries to navigate, such as allowing certain individuals to choose between MMC programs (e.g., Former Foster Care Children ages 18 to 20 years who meet STAR Kids criteria are allowed to choose between STAR Health and STAR Kids). Figure 2 depicts Texas's transition from FFS to MMC over the past 20 years. Collectively, Texas's efforts to transition populations and services into MMC have been successful; as of December 2020, 94 percent of Medicaid clients were enrolled in MMC (Texas Health and Human Services Commission, 2020).

**Figure 2. Texas MMC Growth Over Time<sup>1</sup>**

Source. <sup>1</sup> Medicaid caseloads experienced declines beginning in 2018 due to sustained positive economic conditions and record low unemployment rates. Texas Health and Human Services Commission (2020). Texas Medicaid and CHIP in Perspective: 13th Edition. Austin, TX: Texas Health and Human Services Commission.

MMC=Medicaid managed care; CHIP=Children's Health Insurance Program; STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; STAR Health=MMC program for individuals under or transferring out of conservatorship or foster care; STAR Kids=MMC program serving disabled individuals 20 years and younger; IDD=Intellectual or developmental disability; FFS=Fee-for-service.

Previous research has shown that MMC is designed to improve access to care, quality of care, and care coordination; increase Medicaid budget predictability; and reduce Medicaid spending (The Henry J. Kaiser Family Foundation, 2015). However, as Texas's MMC service delivery model matures, comparisons to historical FFS programs become less informative for driving ongoing program improvement processes. Since MMC is the primary service delivery model for Texas Medicaid beneficiaries, it is imperative to monitor and improve the MMC service delivery model. Throughout the Demonstration, HHSC has implemented new performance-based quality initiatives to help HHSC and MMC Managed Care Organizations (MCOs) identify areas for improvement in the MMC service delivery model. Taken together, these initiatives are designed to promote the expansion of quality-based payments and coordinated care delivery within the MMC delivery system. Appendix C summarizes MMC-related quality initiatives at the time of writing.

During the Extension, Texas will continue to transition additional services and populations into MMC and enhance the current MMC service delivery model to better meet the needs of beneficiaries. Texas will undergo five legislative sessions

during the Extension,<sup>4</sup> which may significantly alter the MMC landscape. Some future legislative actions may substantially alter the service delivery model for MMC beneficiaries, warranting new evaluation questions and hypotheses, while others may not. This evaluation design is meant to span the entire Extension period; however, the MMC evaluation component presented here reflects MMC priorities at the time of writing. Should future MMC changes or initiatives necessitate adjustments to existing plans, or the development of new evaluation questions or hypotheses, this evaluation design will be revised accordingly.<sup>5</sup>

At the time of writing, there are two significant forthcoming changes to MMC which would substantially alter the service delivery model for MMC beneficiaries:<sup>6</sup>

- **STAR+PLUS Pilot Program:** On September 1, 2023, HHSC will implement a STAR+PLUS Pilot Program to test the delivery of long-term services and supports (LTSS) for beneficiaries with an intellectual or developmental disability (IDD), traumatic brain injury, or similar functional need through an MMC delivery model. The pilot program will inform the future carve-in of LTSS into MMC as required by Texas Government Code §534.102. Current statute requires the staggered transition of some or all LTSS for people with IDD to MMC through 2031. Texas's External Quality Review Organization (EQRO) will conduct a pre-post implementation evaluation of the STAR+PLUS Pilot Program. Because the EQRO will be conducting a study on the STAR+PLUS Pilot Program, which will be submitted to CMS, this component is not included in the evaluation of the Extension. If results of the EQRO's study suggest further evaluation of the STAR+PLUS Pilot Program is necessary, or when HHSC begins to carve in LTSS services for these beneficiaries based on results of the STAR+PLUS Pilot Program, this evaluation design plan may be revised.
- **Non-Emergency Medical Transportation (NEMT):** On June 1, 2021, MCOs began providing all NEMT services for MMC beneficiaries. In addition, MCOs began providing demand response transportation services (DRTS) for certain trips with less than 48-hours' notice and HHSC increased

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<sup>4</sup> At the time of writing, the 87<sup>th</sup> Texas Legislature, Regular Session, 2021, had recently concluded. Texas will also convene four additional regular legislative sessions during the Extension (88<sup>th</sup> session in 2023, 89<sup>th</sup> session in 2025, 90<sup>th</sup> session in 2027, and the 91<sup>st</sup> session in 2029); special sessions may also be convened at the direction of the governor.

<sup>5</sup> The 87<sup>th</sup> Texas Legislature passed multiple bills requiring changes to MMC. Some bills impacting MMC will require 1115 waiver amendments and state plan amendments. This evaluation design will be revised to include evaluation questions and hypotheses on pending bill implementations and forthcoming changes to MMC as a result of the 87<sup>th</sup> Texas Legislature, as necessary, at a later date.

<sup>6</sup> This is not a comprehensive list of Demonstration amendments requested by HHSC. Only Demonstration amendments necessitating evaluation questions or hypotheses are included. A full list of Texas 1115 waiver amendments can be found at:

<https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/83231>

opportunities for transportation network companies (TNCs) to provide DRTS.<sup>7</sup> HHSC anticipates increased access to trips with short notice and the expanded participation of TNCs will increase DRTS utilization and improve the overall NEMT service delivery model.

In summary, previous MMC evaluation components of the Demonstration focused primarily on service changes among Medicaid clients whose benefits transitioned from FFS to MMC. However, as MMC has become the service delivery model for most Medicaid beneficiaries, inquiries into individuals transitioning from FFS to MMC are less frequent, increasingly population-specific, and less generalizable to the entire MMC population. In order to ensure findings from the MMC evaluation component are relevant, useful, and well-tailored to the overall goals of the Demonstration, HHSC expanded the scope of the MMC evaluation component during the Extension to assess the quality of Texas MMC in its entirety. This macro-level approach to the MMC evaluation will provide insight into the performance of MMC programs for the Demonstration as a whole, a perspective not explored in previous Demonstration evaluation plans.

## **Directed Payment Programs**

DSRIP provides incentive payments to providers who engage in innovations and reforms that improve access to care, quality of care, population health outcomes, and reduce per capita costs. DSRIP expires September 30, 2021.<sup>8</sup> As a part of the DSRIP transition plan, Texas developed a series of DPPs to sustain key DSRIP initiative areas and support further delivery system reform after DSRIP expires. Though the DPPs operate through the managed care environment, this evaluation design plan includes a stand-alone DPP component due to their unique program structure and policy role as DSRIP successor programs.

This evaluation will focus on five DPPs. Texas currently operates two of these DPPs, QIPP and the Uniform Hospital Rate Increase Program (UHRIP).<sup>9</sup> QIPP will continue operating without substantive changes under the Extension; however, UHRIP will transition to an expanded DPP called CHIRP. Additionally, as part of the DSRIP Transition Plan, and conditional on CMS approval, Texas will implement four new DPPs on September 1, 2021 (Table 2). Descriptions of each of these DPPs can be found in Appendix D.

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<sup>7</sup> A transportation network company means a corporation, partnership, sole proprietorship, or other entity that, for compensation, enables a passenger to prearrange with a driver, exclusively through the entity's digital network, a digitally prearranged ride (e.g., Uber or Lyft; Texas Occupations Code, 2402.001).

<sup>8</sup> The final DSRIP measurement period incorporates calendar year (CY) 2021. Final payments are scheduled for January 2023.

<sup>9</sup> This evaluation focuses on DPPs developed through the DSRIP Transition Plan, and/or DPPs tied to a specific quality goal in the Texas Managed Care Quality Strategy.



**Table 2. Texas Directed Payment Programs Included in Evaluation**

<b>Program Status</b>	<b>DPP<sup>1</sup></b>	<b>Implementation Date</b>	<b>Description</b>
<b>Existing Programs</b>	Quality Incentive Payment Program (QIPP)	September 1, 2017	Performance-based payments to nursing facilities through STAR+PLUS
	Uniform Hospital Rate Increase Program (UHRIP) <sup>2</sup>	December 1, 2017	Increased Medicaid payment for inpatient and outpatient services
<b>New Programs<sup>3</sup></b>	Comprehensive Hospital Increased Reimbursement Program (CHIRP)	September 1, 2021	Incentive payments to hospitals
	Directed Payment Program for Behavioral Health Services (DPP BHS)	September 1, 2021	Incentive payments to Community Mental Health Clinics
	Rural Access to Primary and Preventive Services (RAPPS)	September 1, 2021	Incentive payments to Rural Health Clinics
	Texas Incentives for Physician and Professional Services (TIPPS)	September 1, 2021	Incentive payments to physicians and certain medical professionals

*Notes.* <sup>1</sup> The DPPs included in Table 2 do not reflect all DPPs operating in Texas, only those included in the evaluation. <sup>2</sup> UHRIP will transition to a component of CHIRP and will not be a stand-alone DPP as of September 1, 2021. <sup>3</sup> Implementation of new DPPs is conditional on CMS approval.

DPP=Directed payment program; STAR+PLUS=MMC program serving aged and disabled clients; CMS=Centers for Medicare and Medicaid.

## Supplemental Payment Programs

### Uncompensated Care Pool

Uncompensated care refers to costs associated with hospital care for which no payment was received from the patient or insurer. These payment shortages fall into two categories: charity care and bad debt. Charity care is unreimbursed costs to hospitals for services provided to low-income individuals for free or at reduced prices; hospitals assume minimal payment on behalf of the patient. Bad debt refers to uncollectible inpatient and outpatient charges that result from the extension of credit to the patient after the facility expected payment for care. The possible fiscal impact of uncompensated care on hospitals that serve indigent persons and the entities who reimburse the facilities can be significant. Nationally, UC costs have more than doubled over the past two decades, from \$17 billion in 1995 to \$42 billion in 2019 (American Hospital Association, 2021).

On October 1, 2011, Texas replaced the previous Upper Payment Limit program with the UC program as part of an effort to facilitate the expansion of MMC while continuing to make supplemental payments to hospitals. Texas UC payments were used to reduce the actual uncompensated cost of medical services for both charity care and bad debt (Texas Health and Human Services Commission, 2021). The UC program payment methodology remained consistent from Demonstration Year (DY) 1 to DY8, but transitioned to a charity care only model at the beginning of DY9. The UC program now focuses exclusively on reimbursing costs associated with medical services provided under a provider's charity care policy; cost reimbursements associated with bad debt or Medicaid shortfall were retired. Prior to the transition to charity care only, HHSC implemented UHRIP, a directed payment program requiring MMC MCOs to pay increased reimbursement rates for certain hospital services provided to STAR and STAR+PLUS members.<sup>10</sup> The expansion of UHRIP statewide roughly coincided with the termination of Medicaid shortfall, helping to offset potential financial losses for Texas hospitals.

To receive payments from the UC program, a Medicaid provider must complete an application listing its uncompensated costs for charity care services provided. A hospital may claim uncompensated costs for inpatient and outpatient services, as well as related costs for physician, and pharmacy services. This UC payment methodology based only on charity care will continue throughout the Extension. However, CMS will resize the UC pool in 2022, establishing an amount for 2022-2026, and then again in 2027, with the latter resizing based on the most recent charity care costs from eligible hospital providers.

### **Public Health Provider Charity Care Pool Program**

In addition to the UC program, the Extension will provide new authority for the state to receive federal financial participation for payments made through the PHP-CCP program starting October 1, 2021. Texas developed the PHP-CCP program as part of the DSRIP transition plan to continue financial support for local public providers following the expiration of DSRIP. The PHP-CCP program will provide supplemental payments to publicly-owned and operated community mental health clinics (CMHCs), local behavioral health authorities (LBHAs), local mental health authorities (LMHAs), local health departments (LHDs), and public health districts (PHDs). These payments are intended to help defray uncompensated care costs associated with furnishing medical services to Medicaid eligible or uninsured individuals incurred by qualifying providers following the expiration of DSRIP on September 30, 2021.<sup>11</sup>

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<sup>10</sup> UHRIP was piloted in two service areas on December 1, 2017 and implemented statewide beginning March 1, 2018 (DY7).

<sup>11</sup> PHP-CCP program providers may also participate in DPPs. However, since PHP-CCP eligible providers serve high rates of uninsured individuals, the payments available through DPPs may be lower than payments received under DSRIP. HHSC developed the PHP-CCP program in part to extend financial stability to PHP-CCP eligible providers following the expiration of DSRIP.



During the first year of the PHP-CCP program, payments may be used to defray actual uncompensated care costs, including Medicaid shortfall and bad debt. Starting October 1, 2022, PHP-CCP program payments may only be used to defray costs associated with services provided to patients under the provider's charity care policy. The PHP-CCP program will undergo pool resizing for FFYs 2024-2028, and then again for FFYs 2029-2030, based on a reassessment of providers' uncompensated charity care costs. Similar to the UC program, a provider must submit an annual application to the state containing cost and payment data on services eligible for reimbursement under the PHP-CCP program.

## **Focus of the Evaluation**

The current evaluation, as outlined in this evaluation design plan, focuses primarily on the Extension period (FFY 2021 to FFY 2030). The evaluation builds on prior research conducted during the renewal period, where applicable, for policies and flexibilities carried forward from the previous demonstration approval period.

Specifically, the evaluation of MMC will focus on recent or ongoing changes to Medicaid service delivery (e.g., the carve-in of NEMT and LTSS for certain beneficiaries), as well as an assessment of the overall quality of the MMC service delivery model. The evaluation of DPPs will explore the efficacy of these programs in continuing the successful innovations of DSRIP and advancing key goals in Texas's managed care quality strategy. The evaluation of SPPs will focus on the efficacy of these programs in delivering critical financial support to providers, as well as the impacts of key policy changes on cost and health outcomes (e.g., the transition to charity care only and the introduction of the PHP-CCP program). Finally, the Overall Demonstration evaluation component will investigate cost outcomes for the Demonstration as a whole.

Together, these lines of inquiry will provide insight into whether the state continued making progress towards the goals set forth in the initial Demonstration and met the specific aims of the Extension. Additionally, findings from the evaluation may guide future improvements to the state's healthcare system.

## 2. Evaluation Questions and Hypotheses

Texas developed a series of evaluation questions to assess state performance on the objectives of the Demonstration. The evaluation questions also promote the objectives of Title XIX by examining how quality-based payment systems and the expansion of MMC services support children, pregnant women, low income individuals, and individuals with disabilities in Texas Medicaid. Table 3 shows the alignment between Demonstration objectives, the main components of the Extension, and corresponding evaluation questions.

**Table 3. Demonstration Alignment**

<b>Demonstration Objective</b>	<b>Demonstration Component</b>	<b>Evaluation Question(s)</b>
<b>Expand risk-based managed care to new populations and services.</b>	MMC	Did the expansion of the MMC service delivery model to additional populations or services improve health care outcomes for MMC clients?
<b>Support the development and maintenance of a coordinated care delivery system.</b>	MMC DPPs	Did the MMC service delivery model improve access to and quality of care over time? Do DPPs continue or expand upon the successful innovations of DSRIP? Do DPPs advance at least one of the goals in the managed care quality strategy?
<b>Improve outcomes while containing cost growth.</b>	MMC DPPs SPP	Do the SPPs financially support providers serving the Medicaid and uninsured populations? Did the implementation of UHRIP support the hospital delivery system during the transition of the UC program to charity care only? What are the costs of providing health care services to Medicaid beneficiaries served under the Demonstration? What are the administrative costs of implementing and operating the Demonstration? How do the funding pools administered through the Demonstration support providers and overall Medicaid program sustainability?

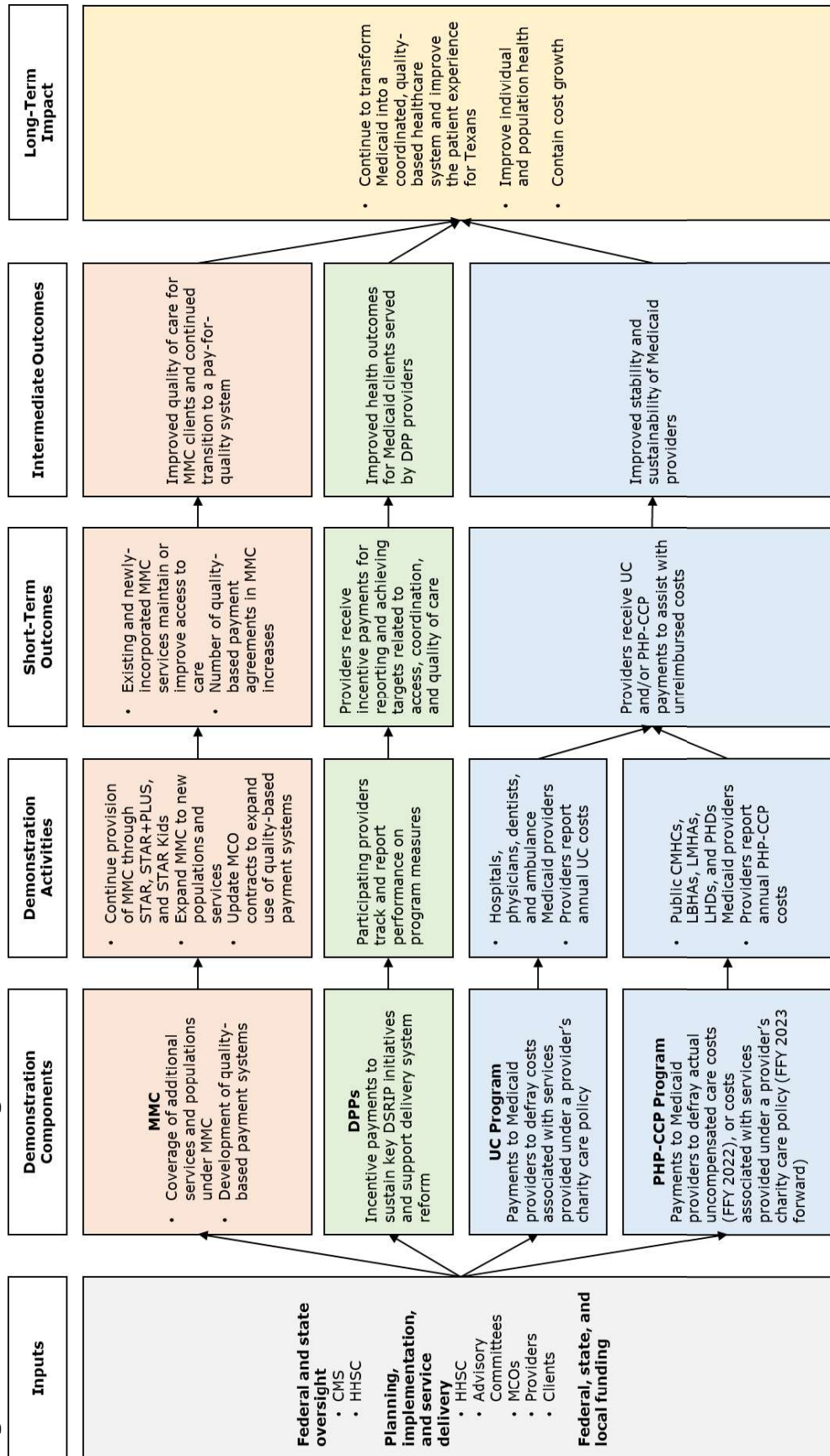
<b>Demonstration Objective</b>	<b>Demonstration Component</b>	<b>Evaluation Question(s)</b>
<b>Transition to quality-based payment systems across managed care and providers.</b>	MMC DPPs	Did Texas's quality initiatives impact the development and implementation of quality-based payment systems?  Do DPPs advance at least one of the goals in the managed care quality strategy?

*Notes.* MMC=Medicaid managed care; DPP=Directed Payment Program; DSRIP=Delivery System Reform Incentive Payment; SPP=Supplemental Payment Program; UHRIP=Uniform Hospital Rate Increase Program; UC=Uncompensated Care.

## Logic Model

The logic model (Figure 3) illustrates the theory of change, or the pathways through which the Demonstration will work to achieve short-term, intermediate, and long-term outcomes during the Extension.

Figure 3. Demonstration Logic Model



**Notes.** CMS=Centers for Medicare and Medicaid Services; HHSC=Health and Human Services Commission; MCO=Managed care organization; MMC=Medicaid managed care; STAR=MMC program for children, newborns, and pregnant women; STAR+PLUS=MMC program for individuals age 21 and older with disabilities and individuals age 65 or older; STAR Kids=MMC program for children and adults age 20 and younger with a disability; DPP=Directed payment program; DSRIP=Delivery System Reform Incentive Payment; UC=Uncompensated Care; PHP-CCP=Public Health Provider Charity Care Pool; FFY=Federal fiscal year, October 1-September 30.

## Evaluation Questions

The evaluation design plan for the Extension includes 10 evaluation questions and 20 hypotheses. The evaluation questions and hypotheses are grouped by the main components of the Extension. Each evaluation question is addressed through a minimum of one corresponding hypothesis and measure. Targets for improvement (e.g., improvement over baseline or pre-period) vary across evaluation measures. Additional details on measure-specific targets for improvement are provided in the Methodology section of this evaluation design plan, as well as Appendix E.

### MMC Component

#### **Evaluation Question 1. Did the expansion of the MMC service delivery model to additional populations or services improve health care outcomes for MMC clients?**

H1.1. Utilization of DRTS will increase for MMC members.

H1.2. Access to health care services will improve for MMC members whose DRTS were carved into MMC.

H1.3. Preventable emergency department use will decrease among Medicaid members whose DRTS were carved into MMC.

#### **Evaluation Question 2. Did the MMC service delivery model improve access to and quality of care over time?**

H2.1. Access to preventive care will maintain or improve over time.

H2.2. Effective treatment of chronic, complex, and serious conditions will maintain or improve over time.

H2.3. Appropriate use of health care will maintain or improve over time.

H2.4. Poor care or care coordination which may result in unnecessary patient harm will maintain or reduce over time.

H2.5. MMC member experience will maintain or improve over time.

#### **Evaluation Question 3. Did Texas's quality initiatives impact the development and implementation of quality-based payment systems?**

H3.1. The implementation of alternative payment models (APMs) in Texas Medicaid will increase over time.

## **DPP Component**

### **Evaluation Question 4. Do DPPs continue or expand upon the successful innovations of DSRIP?**

H4.1. DPPs continue or expand upon DSRIP best practices.

H4.2. DPPs support providers' transition from DSRIP.

### **Evaluation Question 5. Do DPPs advance at least one of the goals in the managed care quality strategy?**

H5.1. DPPs promote optimal health for Texans.

H5.2. DPPs promote effective practices for people with chronic and serious conditions.

H5.3. DPPs promote a safer delivery system that keeps patients free from harm.

## **SPP Component**

### **Evaluation Question 6. Do the SPPs financially support providers serving the Medicaid and uninsured populations?**

H6.1. The UC and PHP-CCP programs financially support Medicaid providers by reimbursing Medicaid or charity care costs in Texas.

### **Evaluation Question 7. Did the implementation of UHRIP support the hospital delivery system during the transition of the UC program to charity care only?**

H7.1. Hospital-based performance measures will maintain or improve following the transition to charity care only in DY9.

## **Overall Demonstration Component**

### **Evaluation Question 8. What are the costs of providing health care services to Medicaid beneficiaries served under the Demonstration?**

H8.1. The Demonstration results in overall savings in health care service expenditures.

### **Evaluation Question 9. What are the administrative costs of implementing and operating the Demonstration?**

H9.1. Administrative costs required to implement and operate the Demonstration are relatively stable and reasonable over time.

**Evaluation Question 10. How do the funding pools administered through the Demonstration support providers and overall Medicaid program sustainability?**

H10.1 The Demonstration leverages savings in health care service expenditures to administer quality-based payment systems and supplemental funding pools.

H10.2 The quality-based payment systems and supplemental funding pools administered through the Demonstration support Medicaid provider operations and sustainability.

### 3. Methodology

Given the scope and breadth of the Demonstration, the evaluation design plan methodology is divided into four sections corresponding to each of the three main components of the Extension (MMC, DPPs, and SPPs), as well as one Overall Demonstration component which investigates cost outcomes for the Demonstration as a whole. Each section includes information on the evaluation design, evaluation measures, study population(s), study period(s), data sources, analytic methods, and methodological limitations. Data, analytic methods, and reporting will meet traditional standards of scientific and academic rigor, as appropriate and feasible for each evaluation component.

Technical specifications for each evaluation measure are described in Appendix E. These specifications include the measure definition; study population; measure steward or source; technical specifications; exclusion criteria; data source or collection method; comparison group or subgroups, where applicable; analytic methods; interpretation; and benchmarks, where applicable.

The methodology described in this evaluation design plan may require changes to align with future innovations or modifications to the Medicaid landscape; in addition, changes may be required to execute the evaluation design plan after key data sources are assessed for completeness and proposed analytic methods are tested. Changes to the evaluation design plan will be documented in Appendix A.

### MMC Evaluation Methods

The MMC evaluation component will utilize a mixed-method approach to address evaluation questions focused on specific changes to the MMC service delivery model and Texas MMC in its entirety. This evaluation will span the entire Extension.<sup>12</sup> At the time of writing, the MMC evaluation component was guided by three evaluation questions: one assessing expansion of the MMC service delivery model to specific populations or services, and two assessing the MMC program in its entirety.

### MMC Evaluation Design

The MMC evaluation component will rely on two quasi-experimental designs: a one-group posttest only design and a one-group pretest-posttest design.

- **One-Group Posttest Only Design:** Measures assessing Texas's entire MMC program will be evaluated with a one-group posttest only design. This design will use consecutive population-based observations of MMC measures to describe changes in MMC operation and performance over time. Measures

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<sup>12</sup> This evaluation design will be revised, as necessary, to incorporate future changes to the MMC service delivery system.



evaluated through a one-group posttest only design will use descriptive statistics and descriptive trend analysis (DTA).

- **One-Group Pretest-Posttest Design:** Measures assessing MMC service delivery changes will be evaluated with a one-group pretest-posttest design. This design will use repeated observations of outcome measures to monitor changes before and after the MMC change. Measures evaluated through a one-group pretest-posttest design will use descriptive statistics, DTA, and interrupted time series (ITS).

Table 4, Table 5, and Table 6 provide an overview of all MMC-specific evaluation questions and hypotheses aligned with their respective measures. The measures selected to assess the entire MMC program reflect the most commonly incentivized performance measures across the state's various MMC quality initiatives. These measures reflect the state's priorities in ongoing MMC performance improvement.<sup>13</sup> Subsequent sections provide additional information on the study populations, study periods, data sources, and analytic methods. Additional details for each of the proposed measures can be found in Appendix E.

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<sup>13</sup> Evaluation measures selected for assessing Texas's MMC program are dependent on continuity of measure stewards and EQRO reporting. Changes in measure specifications or the EQRO contract may disrupt availability of measures over the entire Extension. This evaluation design may be revised, where applicable, if evaluation measures identified in the MMC evaluation component are discontinued.

**Table 4. Evaluation Design Overview, Evaluation Question 1: Did the expansion of the MMC service delivery model to additional populations or services improve health care outcomes for MMC clients?**

<b>Evaluation Hypothesis</b>	<b>Measure(s)</b>	<b>Study Population</b>	<b>Data Source(s) or Data Collection Method(s)</b>	<b>Analytic Methods</b>
<b>H1.1.1. Utilization of DRTS will maintain or increase for MMC members.</b>	1.1.1 MMC members utilizing DRTS per month/quarter 1.1.2 DRTS trips per month/quarter 1.1.3 Average DRTS trips per member per month/ quarter	<ul style="list-style-type: none"> <li>MMC members utilizing DRTS</li> </ul>	<ul style="list-style-type: none"> <li>FFS claims and MMC encounter data</li> <li>Member-level enrollment files</li> <li>Provider-level enrollment data</li> </ul>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>ITS</li> <li>Subgroup analysis<sup>1</sup></li> </ul>
<b>H1.2. Access to health care services will improve for MMC members whose DRTS services were carved into MMC.</b>	1.2.1 Adults' access to preventive/ ambulatory health services (HEDIS®-like) 1.2.2 Child and adolescent well-care visits (HEDIS®) 1.2.3 Utilization of pharmacy benefits	<ul style="list-style-type: none"> <li>MMC members utilizing DRTS</li> </ul>	<ul style="list-style-type: none"> <li>FFS claims and MMC encounter data</li> <li>Member-level enrollment files</li> <li>Member-level pharmacy data</li> <li>Provider-level enrollment data</li> </ul>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> <li>ITS</li> <li>Subgroup analysis<sup>1</sup></li> </ul>
<b>H1.3. Preventable emergency department use will decrease among Medicaid members whose DRTS services were carved into MMC.</b>	1.3.1 Prevention quality overall composite (PQI #90) 1.3.2 Pediatric quality overall composite (PDI #90)	<ul style="list-style-type: none"> <li>MMC members utilizing DRTS</li> </ul>	<ul style="list-style-type: none"> <li>FFS claims and MMC encounter data</li> <li>Member-level enrollment files</li> <li>Provider-level enrollment data</li> </ul>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> <li>ITS, if feasible</li> <li>Subgroup analysis<sup>1</sup></li> </ul>

*Notes.* <sup>1</sup> Subgroup analysis will only be performed where applicable. DRTS=Demand response transportation services; MMC=Medicaid managed care; FFS=Fee-for-service; ITS=Interrupted time series; HEDIS®=Healthcare Effectiveness Data and Information Set; DTA=Descriptive trend analysis; PQI=Prevention quality indicators; PDI=Pediatric quality indicators.

**Table 5. Evaluation Design Overview, Evaluation Question 2: Did the MMC service delivery model improve access to and quality of care over time?**

<b>Evaluation Hypothesis</b>	<b>Measure(s)</b>	<b>Study Population</b>	<b>Data Source(s) or Data Collection Method(s)</b>	<b>Analytic Methods</b>
<b>H2.1. Access to preventive care will maintain or improve over time.</b>	2.1.1 Childhood immunization status (HEDIS®) 2.1.2 Immunizations for adolescents (HEDIS®) 2.1.3 Prenatal and postpartum care (HEDIS®) 2.1.4 Cervical cancer screening (HEDIS®) 2.1.5 Breast cancer screening (HEDIS®)	<ul style="list-style-type: none"> <li>STAR</li> <li>STAR+PLUS</li> <li>STAR Kids</li> </ul>	<ul style="list-style-type: none"> <li>EQRO-calculated MMC performance measures</li> </ul>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> <li>Subgroup analysis<sup>1</sup></li> </ul>
<b>H2.2. Effective treatment of chronic, complex, and serious conditions will maintain or improve over time.</b>	2.2.1 Comprehensive diabetes care (HEDIS®) 2.2.2 Controlling high blood pressure (HEDIS®) 2.2.3 Follow-up care for children prescribed ADHD medication (HEDIS®) 2.2.4 Antidepressant medication management (HEDIS®) 2.2.5 Follow-up after hospitalization for mental illness (HEDIS®) 2.2.6 Initiation and engagement of alcohol and other drug dependence treatment (HEDIS®)	<ul style="list-style-type: none"> <li>STAR</li> <li>STAR+PLUS</li> <li>STAR Kids</li> </ul>	<ul style="list-style-type: none"> <li>EQRO-calculated MMC performance measures</li> </ul>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> <li>Subgroup analysis<sup>1</sup></li> </ul>
<b>H2.3. Appropriate use of health care will maintain or improve over time.</b>	2.3.1 Potentially preventable admissions (3M) 2.3.2 Potentially preventable emergency department visits (3M)	<ul style="list-style-type: none"> <li>STAR</li> <li>STAR+PLUS</li> <li>STAR Kids</li> </ul>	<ul style="list-style-type: none"> <li>EQRO-calculated MMC performance measures</li> </ul>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> <li>Subgroup analysis<sup>1</sup></li> </ul>

<b>Evaluation Hypothesis</b>	<b>Measure(s)</b>	<b>Study Population</b>	<b>Data Source(s) or Data Collection Method(s)</b>	<b>Analytic Methods</b>
<b>H2.4. Poor care or care coordination which may result in unnecessary patient harm will maintain or reduce over time.</b>	2.4.1 Potentially preventable complications (3M) 2.4.2 Potentially preventable readmissions (3M)	<ul style="list-style-type: none"> <li>• STAR</li> <li>• STAR+PLUS</li> <li>• STAR Kids</li> </ul>	<ul style="list-style-type: none"> <li>• EQRO-calculated MMC performance measures</li> </ul>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> <li>• Subgroup analysis<sup>1</sup></li> </ul>
<b>H2.5. MMC member experience will maintain or improve over time.</b>	2.5.1 Getting care quickly composite (CAHPS®) 2.5.2 Getting needed care composite (CAHPS®) 2.5.3 Rating of personal doctor (CAHPS®) 2.5.4 Rating of health plan (CAHPS®)	<ul style="list-style-type: none"> <li>• STAR</li> <li>• STAR+PLUS</li> <li>• STAR Kids</li> </ul>	<ul style="list-style-type: none"> <li>• EQRO-calculated MMC performance measures</li> </ul>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> <li>• Subgroup analysis<sup>1</sup></li> </ul>

Notes. <sup>1</sup> Subgroup analysis will only be performed where applicable. MMC=Medicaid managed care; HEDIS®=Healthcare Effectiveness Data and Information Set; STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; STAR Kids=MMC program serving disabled individuals 20 years or younger; EQRO=Texas's external quality review organization; DTA=Descriptive trend analysis; CAHPS®=Consumer Assessment of Healthcare Providers and Systems.

**Table 6. Evaluation Design Overview, Evaluation Question 3: Did Texas's quality initiatives impact the development and implementation of quality-based payment systems?**

<b>Evaluation Hypothesis</b>	<b>Measure(s)</b>	<b>Study Population</b>	<b>Data Source(s) or Data Collection Method(s)</b>	<b>Analytic Methods</b>
<b>H3.1.1. The implementation of APMs in Texas Medicaid will increase over time.</b>	3.1.1 Percentage of providers implementing APMs	<ul style="list-style-type: none"> <li>• MCOs</li> <li>• DPP Providers</li> </ul>	<ul style="list-style-type: none"> <li>• MCO APM reporting tool</li> <li>• MCO survey</li> <li>• Provider survey</li> </ul>	<ul style="list-style-type: none"> <li>• Content analysis</li> <li>• Descriptive statistics</li> <li>• DTA</li> <li>• Subgroup analysis<sup>1</sup></li> <li>• Thematic content analysis</li> </ul>
	3.1.2 Percentage of MCOs and providers implementing risk-based APMs			
	3.1.3 Percentage of MCO payments made through APMs			
	3.1.4 Perceived benefits of implementing APMs			
	3.1.5 Perceived challenges with implementing APMs			

Notes. <sup>1</sup> Subgroup analysis will only be performed where applicable. APM=Alternative payment model; MCO=Managed care organization; DPP=Directed payment program; DTA=Descriptive trend analysis.

## MMC Study Populations

The MMC study population collectively refers to providers and members participating in the MMC delivery model. Evaluation questions focused on MMC service delivery changes will use eligibility and managed care enrollment criteria to identify study populations. Evaluation questions focused on the entire MMC program will center primarily on MMC program populations, but will also include a sample of MCOs and providers as part of primary data collection efforts. The units of analysis for the MMC evaluation component are MMC members, providers, and MCOs.

At the time of writing, the study population for MMC service delivery changes was:

- **Members utilizing DRTS:** Prior to June 1, 2021, most MMC members received NEMT services through Managed Transportation Organizations (MTOs) operating under the Medical Transportation Program.<sup>14</sup> On June 1, 2021, MCOs began providing all NEMT services for MMC beneficiaries. On this date, MCOs also began allowing members to request DRTS with less than 48-hours' notice and incorporated TNCs (e.g., Uber and Lyft) into the provider network for DRTS. Evaluation measures assessing the impact of implementing NEMT through MMC will focus on DRTS because this is the most frequently used NEMT service and all changes implemented on June 1, 2021 apply to DRTS.<sup>15</sup> If feasible, the external evaluator will create subgroups of members utilizing DRTS to understand differing impacts of the DRTS change on MMC members. Potential subgroups include:
  - *Pre- and Post-DRTS utilizers:* Members who utilized DRTS prior to and after MMC implementation. This subgroup will provide insight into changes associated with the transition from FFS to MMC.
  - *Post-Only DRTS utilizers:* Members who began utilizing DRTS only after MMC implementation. This subgroup will provide insight into impacts associated with receiving DRTS through MMC.

The MMC study populations for the entire MMC program include members served through the following three MMC programs and a sample of DPP providers and MCOs engaging in APMs:<sup>16</sup>

- **STAR:** STAR began in 1993 and is the primary managed care program providing acute care services to children, pregnant women, and some families. Sixty eight percent of Medicaid members are enrolled in STAR (Texas Health and Human Services Commission, 2020).

<sup>14</sup> MMC members in the Dallas/Fort Worth and Houston/Beaumont services areas received NEMT services through Full Risk Brokers. All other MMC members received NEMT services through MTOs.

<sup>15</sup> NEMT services excluded from the evaluation include meals, lodging, public transit, and air travel.

<sup>16</sup> HHSC also administers MMC through STAR Health but this program is not included in the evaluation because it is outside the authority of the Extension.

- **STAR+PLUS:** STAR+PLUS began in 1998 and provides acute care and LTSS to older adults, adults with disabilities, and women with breast or cervical cancer. Thirteen percent of Medicaid members are enrolled in STAR+PLUS (Texas Health and Human Services Commission, 2020).
- **STAR Kids:** STAR Kids began in 2016 and provides acute care and LTSS to children and adults age 20 and younger with disabilities. Four percent of Medicaid members are enrolled in STAR Kids (Texas Health and Human Services Commission, 2020).
- **DPP Providers:** DPP providers will be surveyed to gather provider perspectives on APMs. A wide range of provider types are eligible to participate in DPPs, and all DPP providers contract with MCOs, who administer APMs.
- **MCOs:** HHSC contracts with MCOs to manage and deliver quality health care services to MMC members statewide. At the time of writing, HHSC had contracts with 17 MCOs. MCOs vary in their size, covered service areas, and MMC program offerings.<sup>17</sup> HHSC contractually requires MCOs to establish APMs with providers. By December 31, 2021, MCOs are expected to have at least 50 percent of total provider payments for medical and prescription expenses in APMs, and at least 25 percent in a risk-based model. MCOs contracted to provide MMC in Texas will be surveyed to gather MCO perspectives on APMs.

## Potential Comparison Groups

Although MMC eligibility has changed with the expansion of MMC into new service areas or populations, each point-in-time estimate in the evaluation includes all Medicaid members enrolled in MMC. Individuals not enrolled in MMC at a given point in time are systematically different from those enrolled in MMC; this form of selection bias is inherent to the eligibility criteria and presents significant problems for comparative analysis. As a result, no viable comparison group exists for the MMC program as a whole.

Analyses focused on MMC service delivery changes may allow for the use of a comparison group depending on the context of the change. At the time of writing, the one MMC service delivery change included in the MMC evaluation component (DRTS) has been implemented statewide, so a comparison group of similar Texas MMC members without access to DRTS services does not exist.<sup>18</sup> The evaluation of DRTS will use a historical cohort, however, to assess the transition from FFS to MMC.

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<sup>17</sup> Additional information on MCOs contracted to deliver MMC can be accessed at: <https://www.hhs.texas.gov/services/health/medicaid-chip/provider-information/managed-care-organization-dental-maintenance-organization-provider-services-contact-information>

<sup>18</sup> Potential comparison groups for future changes to the MMC landscape will be assessed as necessary. Should a future MMC service delivery change allow the use of a comparison group, this evaluation design will be updated accordingly.



State and national benchmarks will be leveraged, where feasible, to support interpretation of findings. Importantly, benchmarks at the state or national level may not be representative of MMC members and may not be available at the subgroup level (e.g. by race/ethnicity or age). As a result, direct comparisons between MMC members and state or national benchmarks should be interpreted with caution.

### MMC Study Periods

Pre- and post-study periods for MMC service delivery changes will be anchored to the date when the change occurred. Pre- and post-study periods for the entire Texas MMC program reflect data points available for MMC programs prior to or after implementation of the Demonstration (2011). STAR Kids began in November 2016 so STAR Kids data are not available in the pre-Demonstration period (prior to 2011). Table 7 reflects the study periods for the MMC components at the time of writing.

**Table 7. Study Periods for the MMC Evaluation Component**

MMC Component	Study Population	Pre-Period	Post-Period
<b>MMC Service Delivery Changes</b>	Members utilizing DRTS	September 1, 2017 – May 31, 2021	June 1, 2021 – May 31, 2026
<b>Texas MMC Program<sup>1</sup></b>	STAR	September 1, 2006 – December 31, 2011 <sup>2</sup>	January 1, 2012 – December 31, 2029 <sup>3</sup>
	STAR+PLUS	September 1, 2006 – December 31, 2011 <sup>2</sup>	January 1, 2012 – December 31, 2029 <sup>3</sup>
	STAR Kids	N/A	January 1, 2017 – December 31, 2029 <sup>3</sup>

*Notes.* <sup>1</sup> Not all measures for the Texas MMC program may be available for the entire the pre- and post-periods. The external evaluator will use the all data available for each measure. <sup>2</sup> Prior to January 1, 2010, the EQRO calculated Texas MMC program measures each State Fiscal Year (September 1 – August 31). Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each Calendar Year (January 1 – December 31). As a result, pre- and post-periods for Texas MMC program measures do not align with DYs. <sup>3</sup> The post-period ends on December 31, 2029, the last full calendar year before the Extension approval period ends. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report.

MMC=Medicaid managed care; DRTS=Demand response transportation services; STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; STAR Kids=MMC program serving disabled individuals 20 years or younger.



## MMC Data Sources

The MMC evaluation component will include both quantitative and qualitative data. These data include both primary and secondary data sources, as outlined below.

### MMC Primary Data Source

- **MCO survey:** MCOs will be surveyed regarding their experiences planning and implementing APMs. This survey will be developed by the external evaluator but should include questions to address Evaluation Question 7 and related hypotheses.
- **Provider survey:** MMC providers will be surveyed regarding their experiences planning and implementing APMs. This survey will be developed by the external evaluator but should include questions to address Evaluation Question 3 and related hypotheses. In lieu of a stand-alone survey, the external evaluator may combine primary data collection activities with providers across evaluation components into a single survey.

### MMC Secondary Data Sources

- **Benchmark data:** The evaluation will leverage ongoing reporting of state and national benchmarks. The Texas Healthcare Learning Collaborative (THLC) online portal and aggregate results published by the National Committee for Quality Assurance and the Agency for Healthcare Research and Quality will be used to develop evaluation-specific benchmarks, where applicable.
- **EQRO-calculated MMC performance measures:** Texas's EQRO (The Institute for Child Health Policy (ICHP)) designed and operates the THLC Portal. The THLC portal is an online learning collaborative that includes a graphical user interface that allows the public, MCOs, and HHSC to visualize healthcare metrics. The THLC portal reports on MCO and Dental Maintenance Organization (DMO) performance across a variety of measures, including Healthcare Effectiveness Data and Information Set (HEDIS®), Consumer Assessment of Healthcare Providers and Systems (CAHPS®), and PPEs. The THLC Portal will be used to obtain MMC program-level outcome measures over time. Subgroup estimates for MMC program-level outcome measures will also be obtained from the THLC portal, or directly from ICHP.<sup>19</sup>
- **FFS claims and MMC encounter Data:** FFS claims and MMC encounter data have been processed by the Texas Medicaid and Healthcare Partnership (TMHP) since January 1, 2004. TMHP performs internal edits for data quality and completeness. The member-level claims/encounter data contain the

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<sup>19</sup> Additional information on MMC program-level outcome measures is presented in HHSC's Rider 61 Final Comprehensive Report: Evaluation of Medicaid and CHIP Managed Care, August 2018. This evaluation was conducted in partnership with Deloitte LLP and is accessible via: <https://www.hhs.texas.gov/reports/2018/08/rider-61-evaluation-medicaid-chip-managed-care>.

Current Procedural Terminology (CPT) codes; the International Classification of Diseases, 10<sup>th</sup> Revision, Clinical Modification (ICD-10-CM) codes; place of service codes; and other information necessary to calculate outcome measures related to MMC service delivery changes. Claims and encounter data are adjudicated on an approximate eight-month time lag. Prior analyses with Texas data showed that, on average, over 96 percent of the claims and encounters are complete by that timeframe.

- **MCO APM reporting tool:** Starting September 1, 2018, HHSC required MCOs to report on their APM activities, both implemented and planned. Information from this tool will be used to learn about the types of APMs implemented throughout the Texas Medicaid program.
- **Member-level enrollment files:** The enrollment files contain information about the person's age, gender, race/ethnicity, county, health care service delivery model (i.e., FFS or MMC), MCO enrollment, and length of enrollment. The member-level enrollment files will be used to identify members and member-level subgroups for measures related to MMC service delivery changes. Member-level enrollment files are subject to an approximate eight-month time lag.
- **Member-level pharmacy data:** The member-level pharmacy data contain information about filled prescriptions, including the drug name, dose, date filled, number of days prescribed, and refill information. The member-level pharmacy will be used to calculate outcome measures related to MMC service delivery changes. Member-level pharmacy data are subject to an approximate one-month time lag.
- **Provider-level enrollment files:** Provider-level enrollment files contain information on National Provider Identifier (NPI), Texas Provider Identifier (TPI), provider location, provider type, and provider specialty. Provider data will be sourced from TMHP and an HHSC Structured Query Language (SQL) database, and are subject to a one-month lag. The provider-level enrollment files will be used to identify provider samples for the APM survey, and to develop provider-level subgroups for measures related to MMC service delivery changes.

## MMC Proposed Analytic Methods

Quantitative and qualitative methods will be used for the MMC evaluation component. This section describes the proposed analytic strategies for examining the measures presented in Table 4, Table 5, and Table 6. Analytic methods will incorporate subgroup analyses (e.g., by age, race/ethnicity, region), where feasible, to strengthen the validity of observed outcomes.

## Quantitative Analysis

### Descriptive Statistics

All MMC evaluation measures—except open-ended primary data collection questions—may be examined through a variety of descriptive and inferential statistics. Descriptive statistics include estimates of central tendency and

dispersion. Potential inferential analyses include bivariate statistics, parametric tests (e.g., paired or unpaired t-tests), and non-parametric tests (e.g., McNemar's test, Wilcoxon signed-rank test). Importantly, some measures may not be suited to inferential statistics, such as those that rely on population-level data rather than a sample. The external evaluator will ensure the correct application of statistical testing depending on whether the data is population- or sample-based, whether the measure is categorical or continuous, and whether the data meet the assumptions of parametric tests (e.g., normality, independence).

### **Descriptive Trend Analysis**

Texas has operated MMC in some capacity for over 25 years. Previous evaluation designs have conducted pre-post studies on the implementation of specific MMC programs or populations. Given the long-standing nature of MMC in the state of Texas, there is not a pre-period under the Demonstration that is free of MMC implementation, rendering preferred time-series designs such as ITS infeasible. DTA is an alternative approach to time-series analysis for programs that do not have pre-period data. DTA plots and analyzes time-series data calculated at equally spaced intervals to explain patterns in selected measures over time. DTA typically focuses on identification and quantification of a trend through the use of correlation coefficients and ordinary least squares regression. DTA will be used for all quantitative measures under Evaluation Question 2 and Evaluation Question 3, if feasible, and some measures under Evaluation Question 1 if the recommended minimum number of observations for ITS are not available (i.e., a minimum of eight pre- and eight post-MMC transition time points).

### **Interrupted Time Series**

ITS analysis uses aggregate data collected over equally spaced intervals before and after a policy change to measure changes in outcomes over time. A key assumption of ITS is that data trends before the policy change can be extrapolated to predict trends had the policy change not occurred. If an MMC service delivery change has an impact on an outcome of interest, the post-transition trend will have a slope that is statistically different from the pre-transition trend. When properly executed, ITS is a valuable method to evaluate the success, failure, or unintended consequences of health care policy on outcomes (Lagarde, 2012). However, given the serial nature of ITS data, autocorrelation, nonstationarity, and seasonality need to be considered. Failing to assess and correct for these factors can lead to biased results (Wagner, Soumerai, Zhang, & Ross-Degnan, 2002). A key strength of ITS methodology is that a control site is not required, providing an alternate method of measuring the effect of an intervention "when randomization or identification of a comparison group are impractical" (Grimshaw, et al., 2003). The ITS method allows the target population to serve as its own comparison group in the pre-post analysis.

For outcome measures using ITS, the basic segmented regression model with one intervention or change point examines the outcome of interest ( $Y_t$ ) over time, before and after the policy change:

$$Y_t = \beta_0 + \beta_1 time + \beta_2 MMC\ transition + \beta_3 postslope + \varepsilon_t$$

From the basic statistical model,  $\beta_0$  reflects the baseline level of the outcome at the beginning of the pre-period;  $\beta_1$  estimates the trend before the MMC transition;  $\beta_2$  estimates the immediate impact of the MMC transition; and  $\beta_3$  reflects the change in trend after the MMC transition. To ease interpretation, ITS results are presented as: baseline level, trend before MMC service delivery change, level change after MMC service delivery change, and trend after MMC service delivery change.

ITS will be attempted for all measures under Evaluation Question 1, but measures calculated annually may not have the required number of observations necessary for ITS (i.e., a minimum of eight pre- and eight post-MMC transition time points).

## Qualitative Analysis

### Content Analysis

Content analysis systematically examines documents to extract descriptive data that can be quantified (Vaismoradi, Turunen, & Bondas, 2013) in a structured dataset for statistical testing. This method will be applied to secondary data sources to identify the types of APMs MCOs have with MMC providers (e.g., MCO APM reporting tool). Once documents have been reviewed and coded into quantifiable data, descriptive statistics can be calculated to summarize trends in APM type, APM payment, provider type, or other variables of interest.

### Thematic Content Analysis

Whereas content analysis aims to quantify qualitative data by counting frequencies of codes or phrases, thematic content analysis aims to understand and describe patterns or themes in the data using inductive or deducting reasoning (Vaismoradi, Turunen, & Bondas, 2013). Thematic content analysis will be used to describe responses to open-ended responses related to APM planning and/or implementation, as well as perceived benefits/barriers to APM development and implementation. A strength of thematic content analysis is its ability to examine similarities and differences in the perspectives of study participants (Nowell, Norris, White, & Moules, 2017), such as the differences between MCOs and providers on the benefits and barriers of APMs.

## MMC Methodological Limitations

Most measures in the MMC evaluation component include the entire MMC population. As a result, observed changes in the evaluation measures reflect the population parameter rather than a sampling estimate. Parametric tests of hypotheses rely on sampling theory to produce estimates of sampling error, which make statistical testing, coefficient estimators, and standard errors meaningful. With population-level data, the application of sampling theory that undergirds inferential statistics (e.g., t-tests) is not meaningful in the traditional sense because there is no sample from which to make inferences about the population.

Nevertheless, the external evaluator may apply statistical testing to observed population differences to better understand the magnitude of observed changes.

Measures using the entire MMC population are limited by the lack of a comparison group. Analyses focused on MMC service delivery changes will explore and develop comparison groups, if feasible. Analyses focused on MMC service delivery changes will also use pre-period data, rigorous quasi-experimental designs, subgroup analyses, and state and national benchmarks, where applicable. However, for MMC service delivery changes without a true comparison group, differences in outcomes may not imply causality.

Another limitation associated with the MMC evaluation component is the use of administrative data. These data have been designed and collected for billing purposes but are used in the evaluation to determine changes in access to and quality of care. Nevertheless, most measures derived from administrative sources in this section are validated and widely used for evaluation purposes. In addition, TMHP performs internal edits for data quality and completeness to help ensure data reliability.

Use of administrative data is also limited by data lags, which pose a challenge to measuring and reporting changes in a timely manner (Schoenberg, Heider, Rosenthal, Schwartz, & Kaye, 2015). Measures using FFS claims or MMC encounters require an approximate eight-month data lag for claims adjudication.

Conclusions derived from qualitative data analysis will be susceptible to common threats to validity, such as selection or sampling bias, recall bias, and social desirability bias. The number of survey waves may also be limited due to study timelines, survey logistics, and the level of effort required to conduct and analyze primary data collection.

Lastly, study periods for the MMC evaluation component span the COVID-19 pandemic. Because the COVID-19 pandemic will impact all components of the evaluation, additional details regarding the implications of the pandemic are presented in the larger Methodological Limitations section on page 65.

Despite these limitations, the MMC evaluation component will provide insight into MMC service delivery changes, as well as the long-term performance of the MMC program in its entirety. This evaluation component will inform whether Texas has continued making progress towards expanding risk-based managed care to new populations and services, and transforming Medicaid to a coordinated, quality-based healthcare system.

## DPP Evaluation Methods

HHSC developed a series of DPPs to sustain key DSRIP initiative areas and support further delivery system reform following the expiration of the DSRIP pool on September 30, 2021. DPP development was informed by the performance of DSRIP providers, a review of the individuals served by DSRIP, and input from key stakeholders.

The DPP component of the Extension includes five DPPs. The first—QIPP—began in SFY 2018 and is expected to continue operating without substantive changes under the Extension. Four new DPPs are scheduled to take effect on September 1, 2021: CHIRP, DPP BHS, RAPPS, and TIPPS.<sup>20</sup> Descriptions of each of these DPPs can be found in Appendix D.

## DPP Evaluation Design

The DPP evaluation component will rely on two quasi-experimental designs: a one-group posttest only design and a one-group pretest-posttest design.

- **One-Group Posttest Only Design:** Measures available only after DPP implementation will be evaluated with a one-group posttest only design. This design will use consecutive observations of DPP measures in the post-DPP implementation period only. This evaluation design is vulnerable to threats to validity and will only be used in cases where pre-DPP implementation data are unavailable. Measures evaluated through a one-group posttest only design will use descriptive statistics and DTA, if feasible.
- **One-Group Pretest-Posttest Design:** Measures available for DPPs and predecessor programs (e.g., DSRIP and UHRIP) will be evaluated with a one-group pretest-posttest design.<sup>21</sup> This design will use repeated observations of outcome measures to monitor changes before and after DPP implementation. Measures evaluated through a one-group pretest-posttest design will use descriptive statistics and DTA, if feasible.

To strengthen these designs, the evaluation will leverage state and national benchmarks, where feasible, to help substantiate and contextualize results. Table 8 and Table 9 provide an overview of all DPP-specific evaluation questions and hypotheses aligned with their respective measures. Subsequent sections provide additional information on the study population, study periods, data sources, and analytic methods. Additional details for each of the proposed measures can be found in Appendix E.

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<sup>20</sup> The four new DPPs are contingent upon CMS approval. This evaluation design will be revised accordingly if CMS does not approve any of the new DPPs.

<sup>21</sup> This design is contingent upon having a sufficient sample size of providers who participated in DSRIP or UHRIP in the pre-period and one of the DPPs in the post-period. If a large enough sample is not achievable, all measures will be evaluated with a one-group posttest only design.

**Table 8. Evaluation Design Overview, Evaluation Question 4: Do DPPs continue or expand upon the successful innovations of DSRIP?**

<b>Evaluation Hypothesis</b>	<b>Measure(s)</b>	<b>Study Population</b>	<b>Data Source(s) or Data Collection Method(s)</b>	<b>Analytic Methods</b>
<b>H4.1. DPPs continue or expand upon DSRIP best practices.</b>	4.1.1 SDA learning collaborative participation	<ul style="list-style-type: none"> <li>CHIRP providers</li> </ul>	<ul style="list-style-type: none"> <li>DPP reporting</li> <li>Provider-level eligibility files</li> </ul>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> <li>Subgroup analysis<sup>1</sup></li> </ul>
	4.1.2 Care team includes personnel in a care coordination role not requiring clinical licensure	<ul style="list-style-type: none"> <li>RAPPS providers</li> <li>TIPPS providers</li> </ul>	<ul style="list-style-type: none"> <li>DPP reporting</li> <li>Provider-level eligibility files</li> </ul>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> <li>Subgroup analysis<sup>1</sup></li> </ul>
	4.1.3 Same-day, walk-in, or after-hours appointments in the outpatient setting	<ul style="list-style-type: none"> <li>TIPPS providers</li> </ul>	<ul style="list-style-type: none"> <li>DPP reporting</li> <li>Provider-level eligibility files</li> </ul>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> <li>Subgroup analysis<sup>1</sup></li> </ul>
	4.1.4 Pre-visit planning and/or standing order protocols			
	4.1.5 Provide patients with services by using remote technology	<ul style="list-style-type: none"> <li>DPP BHS providers</li> </ul>	<ul style="list-style-type: none"> <li>DPP reporting</li> <li>Provider-level eligibility files</li> </ul>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> <li>Subgroup analysis<sup>1</sup></li> </ul>
<b>H4.2. DPPs support providers' transition from DSRIP.</b>	4.2.1 Number of DPP providers	<ul style="list-style-type: none"> <li>DPP providers</li> </ul>	<ul style="list-style-type: none"> <li>DPP reporting</li> </ul>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> </ul>
	4.2.2 Continuity of participation across DSRIP and DPPs	<ul style="list-style-type: none"> <li>Previous DSRIP providers</li> </ul>	<ul style="list-style-type: none"> <li>DSRIP reporting</li> <li>HHSC-estimated DPP payment data</li> </ul>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> <li>Subgroup analysis<sup>1</sup></li> </ul>
	4.2.3 Incentive payments made to providers		<ul style="list-style-type: none"> <li>Provider-level eligibility files</li> </ul>	



<b>Evaluation Hypothesis</b>	<b>Measure(s)</b>	<b>Study Population</b>	<b>Data Source(s) or Data Collection Method(s)</b>	<b>Analytic Methods</b>
	4.2.4 Perceived successes and challenges 4.2.5 Provider perspectives on state priorities and policy development	<ul style="list-style-type: none"> <li>DPP providers who participated in DSRIP</li> </ul>	<ul style="list-style-type: none"> <li>Provider survey</li> </ul>	<ul style="list-style-type: none"> <li>Thematic content analysis</li> </ul>

Notes. <sup>1</sup> Subgroup analysis will only be performed where applicable. DPP=Directed payment program; DSRIP=Delivery System Reform Incentive Payment; SDA=Service delivery area; CHIRP=Comprehensive Hospital Increased Reimbursement Program; DTA=Descriptive trend analysis; RAPPs=Rural Access to Primary and Preventive Services; TIPPS=Texas Incentives for Physician and Professional Services; DPP BHS=Directed Payment Program for Behavioral Health Services; HHSC=Health and Human Services Commission.

**Table 9. Evaluation Design Overview, Evaluation Question 5: Do DPPs advance at least one of the goals in the managed care quality strategy?**

<b>Evaluation Hypothesis</b>	<b>Measure(s)</b>	<b>Study Population</b>	<b>Data Source(s) or Data Collection Method(s)</b>	<b>Analytic Methods</b>
<b>H5.1. DPPs promote optimal health for Texans.</b>	5.1.1 Maternity care: Post-partum follow-up and care coordination	<ul style="list-style-type: none"> <li>TIPPS clients</li> </ul>	<ul style="list-style-type: none"> <li>DPP reporting</li> <li>DSRIP reporting</li> <li>Provider-level eligibility files</li> </ul>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> <li>Subgroup analysis<sup>1</sup></li> </ul>
	5.1.2 Childhood immunization status (HEDIS <sup>®</sup> )			
	5.1.3 Preventive care and screening: Influenza Immunization	<ul style="list-style-type: none"> <li>CHIRP clients</li> <li>RAPPs clients</li> <li>TIPPS clients</li> <li>QIPP residents</li> </ul>	<ul style="list-style-type: none"> <li>DPP reporting</li> <li>DSRIP reporting</li> <li>Long-stay MDS data</li> <li>Provider-level eligibility files</li> </ul>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> <li>Subgroup analysis<sup>1</sup></li> </ul>



<b>Evaluation Hypothesis</b>	<b>Measure(s)</b>	<b>Study Population</b>	<b>Data Source(s) or Data Collection Method(s)</b>	<b>Analytic Methods</b>
	5.1.4 Comprehensive diabetes care: Hemoglobin A1c (HbA1c) testing (HEDIS®)	<ul style="list-style-type: none"> <li>• RAPPs clients</li> <li>• TIPPS clients</li> </ul>	<ul style="list-style-type: none"> <li>• DPP reporting</li> <li>• DSRIP reporting</li> <li>• Provider-level eligibility files</li> </ul>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> <li>• Subgroup analysis<sup>1</sup></li> </ul>
<b>H5.2. DPPs promote effective practices for people with chronic and serious conditions.</b>	5.2.1 Comprehensive diabetes care: Hemoglobin A1c (HbA1c) poor control (>9.0%; HEDIS®)	<ul style="list-style-type: none"> <li>• TIPPS clients</li> </ul>	<ul style="list-style-type: none"> <li>• DPP reporting</li> <li>• DSRIP reporting</li> <li>• Provider-Level eligibility files</li> </ul>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> <li>• Subgroup analysis<sup>1</sup></li> </ul>
	5.2.2 Controlling high blood pressure (HEDIS®)			
	5.2.3 Percentage of nursing facility residents who received an antipsychotic medication	<ul style="list-style-type: none"> <li>• QIPP residents</li> </ul>	<ul style="list-style-type: none"> <li>• Long-stay MDS data</li> <li>• Provider-Level eligibility files</li> </ul>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> <li>• Subgroup analysis<sup>1</sup></li> </ul>
	5.2.4 Follow-up after hospitalization for mental illness (7-Day and 30-day; HEDIS®)	<ul style="list-style-type: none"> <li>• DPP BHS clients</li> </ul>	<ul style="list-style-type: none"> <li>• DPP reporting</li> <li>• DSRIP reporting</li> <li>• Provider-Level eligibility files</li> </ul>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> <li>• Subgroup analysis<sup>1</sup></li> </ul>

<b>Evaluation Hypothesis</b>	<b>Measure(s)</b>	<b>Study Population</b>	<b>Data Source(s) or Data Collection Method(s)</b>	<b>Analytic Methods</b>
<b>H5.3. DPPs promote a safer delivery system that keeps patients free from harm.</b>	5.3.1 Catheter-associated urinary tract infections	<ul style="list-style-type: none"> <li>CHIRP clients</li> </ul>	<ul style="list-style-type: none"> <li>DPP reporting</li> <li>DSRIP reporting</li> <li>Provider-Level eligibility files</li> </ul>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> <li>Subgroup analysis<sup>1</sup></li> </ul>
	5.3.2 Central line-associated bloodstream infections			
	5.3.3 Percentage of nursing facility residents whose ability to move independently has worsened	<ul style="list-style-type: none"> <li>QIPP residents</li> </ul>	<ul style="list-style-type: none"> <li>Long-stay MDS data</li> <li>Provider-level eligibility files</li> </ul>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> <li>Subgroup analysis<sup>1</sup></li> </ul>
	5.3.4 Percentage of nursing facility residents with a urinary tract infection			
	5.3.5 Percentage of high-risk nursing facility residents with pressure ulcers, including unstageable ulcers			

Notes. <sup>1</sup> Subgroup analysis will only be performed where applicable. DPP=Directed payment program; HEDIS<sup>®</sup>=Healthcare Effectiveness Data and Information Set; DPP BHS=Directed Payment Program for Behavioral Health Services; DSRIP=Delivery System Reform Incentive Payment; MDS=Minimum data set; DTA=Descriptive trend analysis; TIPPS=Texas Incentives for Physician and Professional Services; CHIRP=Comprehensive Hospital Increased Reimbursement Program; RAPPs=Rural Access to Primary and Preventive Services; QIPP=Quality Incentive Payment Program.

## DPP Study Populations

DPP providers will serve as the study population for the DPP evaluation component. Table 10 details the specific providers eligible for each DPP, as well as the clients they serve.

**Table 10. DPP Study Populations**

<b>DPP</b>	<b>Type of Provider</b>	<b>Eligible Provider Classes</b>	<b>Clients Served</b>
<b>CHIRP</b>	Hospitals	<ol style="list-style-type: none"> <li>1. Children's hospitals</li> <li>2. Non-state-owned IMDs</li> <li>3. Rural hospitals</li> <li>4. State-owned hospitals that are not IMDs</li> <li>5. State-owned IMDs</li> <li>6. Urban hospitals</li> </ol>	Adults and children enrolled in STAR and STAR+PLUS
<b>DPP BHS</b>	CMHCs	<ol style="list-style-type: none"> <li>1. CMHCs that have attained certification as a CCBHC</li> <li>2. CMHCs that have not attained certification as a CCBHC</li> </ol>	Adults and children enrolled in STAR, STAR+PLUS, and STAR Kids
<b>RAPPS</b>	RHCs	<ol style="list-style-type: none"> <li>1. Hospital-based RHCs</li> <li>2. Freestanding RHCs</li> </ol>	Adults and children enrolled in STAR, STAR+PLUS, and STAR Kids
<b>TIPPS</b>	Physician practice groups	<ol style="list-style-type: none"> <li>1. Physician groups affiliated with an HRI</li> <li>2. Physician groups affiliated with a hospital receiving the IME add-on</li> <li>3. Other physician practice groups that are not HRI or IME</li> </ol>	Adults and children enrolled in STAR, STAR+PLUS, and STAR Kids
<b>QIPP</b>	Nursing facilities	<ol style="list-style-type: none"> <li>1. Non-state-owned governmental entities designated as nursing facilities operated by a hospital authority, hospital district, health district, city, or county</li> <li>2. Privately-owned facilities that have at least 65 percent Medicaid utilization</li> </ol>	Adults in Medicare- or Medicaid-certified nursing facilities

*Notes.* DPP=Directed payment program; CHIRP=Comprehensive Hospital Increased Reimbursement Program; IMD=Institution for mental diseases; STAR=MMC program for children, newborns, and pregnant women; STAR+PLUS=MMC program for individuals age 21 and older with disabilities and individuals age 65 or older; DPP BHS=Directed Payment Program for Behavioral Health Services; CMHC=Community mental health clinic; CCBHC=Certified community behavioral health clinic; STAR Kids=MMC program for children and adults age 20 and younger with a disability; RAPPS=Rural Access to Primary and Preventive Services; RHC=Rural Health Clinic; TIPPS=Texas Incentives for Physician and Professional Services; HRI=Health-related institution; IME=Indirect medical education; QIPP=Quality Incentive Payment Program.

## Potential Comparison Groups

The DPP evaluation component relies heavily on provider-reported data. Because providers who do not participate in DPPs will not be required to report these data, no viable comparison group exists for the DPP evaluation component.

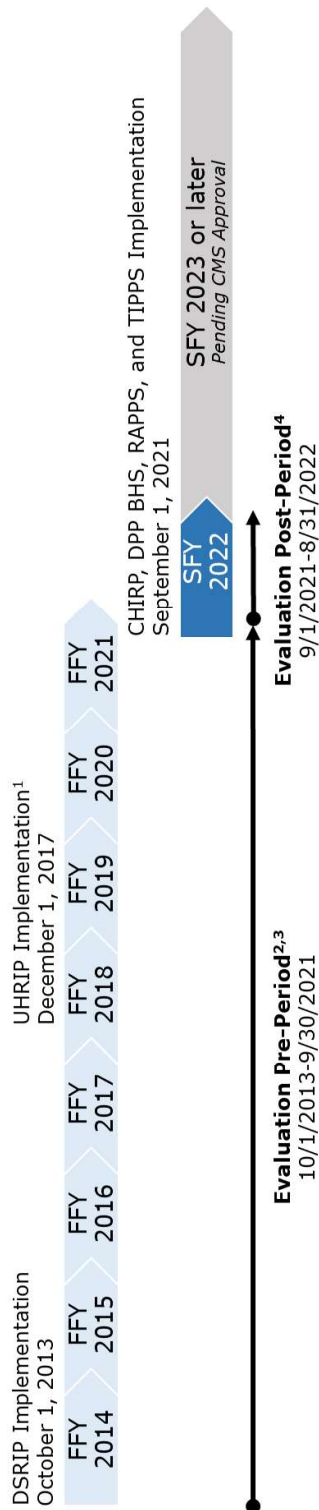
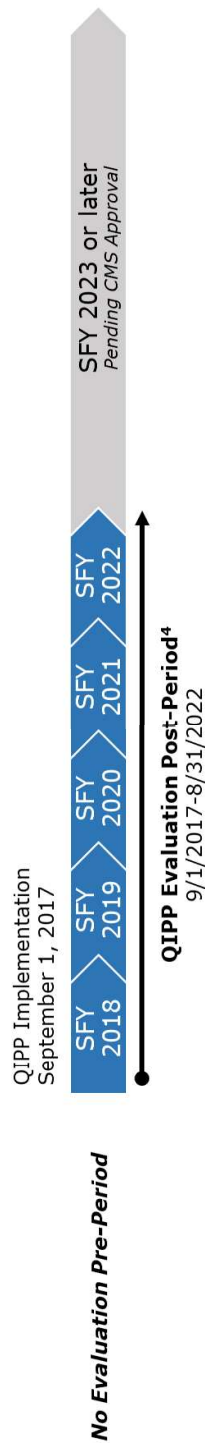
The evaluation design leverages state benchmarks, where feasible, to support interpretation of findings. Importantly, benchmarks at the state level may not be representative of clients who receive services from DPP providers and may not be available at the subgroup level (e.g. by race/ethnicity or age), or at the same time intervals as the Demonstration. As a result, direct comparisons between DPP provider-reported data and state benchmarks should be interpreted with caution.

## DPP Study Periods

At the time of writing, the DPP evaluation component includes one year of DPP implementation data (SFY 2022).<sup>22</sup> The DPP evaluation component may leverage DSRIP and/or UHRIP reporting data to create a pre-DPP implementation period, where available. Figure 4 shows the evaluation periods for the DPP component. Darker cells reflect the anticipated implementation period for each DPP while lighter cells indicate potential pre-periods for certain DPP evaluation measures. As shown in Figure 4, DSRIP may serve as a pre-period for CHIRP, DPP BHS, RAPPs, and TIPPS. UHRIP may also serve as a pre-period for CHIRP, as UHRIP is its predecessor program. QIPP will not have a pre-period in the evaluation.

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<sup>22</sup> The DPPs require CMS approval annually. The initial DPP preprints are applicable through August 31, 2022. HHSC plans to extend the DPPs for additional implementation years. Should CMS approve additional years of DPP implementation, the DPP evaluation component will be expanded to include additional years of data.

**Figure 4. Study Periods for DPP Evaluation Component****Evaluation Study Periods for CHIRP, DPP BHS, RAPPs, and TIPPS****Evaluation Study Periods for QIPP**

Notes. Lighter cells indicate potential pre-periods for the evaluation. Not all post-period measures will have corresponding pre-period measures. <sup>1</sup> UHRIP began 12/1/2017 but was not available statewide until 3/1/2018. <sup>2</sup> CHIRP continues and expands upon UHRIP. CHIRP utilizes UHRIP as the evaluation pre-period for the component similar to UHRIP, and DSRIP for the evaluation pre-period for all other components, where applicable. DPP BHS, TIPPS, and RAPPs only utilize DSRIP for the evaluation pre-period. <sup>3</sup> Because DSRIP measures are reported on FFYs and DPP measures are reported on SFYs, there will be a one-month overlap between the pre- and post-periods. <sup>4</sup> The preprints for CHRRP, DPP BHS, TIPPS, RAPPs, and QIPP are applicable through August 31, 2022. HHSC plans to extend the DPPs for additional implementation years. Should CMS approve additional years of DPP implementation, the DPP evaluation component will be expanded to include additional years of data. CHIRP=Comprehensive Hospital Increased Reimbursement Program; DPP BHS=Directed Payment Program for Behavioral Health Services; TIPPS=Texas Incentives for Physician and Professional Services; RAPPs=Rural Access to Primary and Preventive Services; DSRIP=Delivery System Reform Incentive Payment; UHRIP=Uniform Hospital Rate Increase Program; FFY=Federal fiscal year (October 1-September 30); SFY=State fiscal year (September 1-August 31); QIPP=Quality Incentive Payment Program; CMS=Centers for Medicare and Medicaid Services.

## DPP Data Sources

The DPP evaluation component will include both quantitative and qualitative data. These data include both primary and secondary data sources, as outlined below.

### DPP Primary Data Source

- Provider survey:** The perspectives of providers offer valuable insight about the successes and challenges of DPPs in supporting the transition from DSRIP not otherwise available through provider-reported or administrative data sources. Primary data collection will assess provider feedback regarding the transition from DSRIP to DPPs. The external evaluator will determine the most appropriate data collection approach and develop corresponding instruments and/or guides. If feasible, the external evaluator should make efforts to assure primary data collection activities target providers of different types, sizes, and geographic regions to ensure a range of provider perspectives are included. In lieu of a stand-alone survey, the external evaluator may choose to combine primary data collection activities with providers across evaluation components into a single survey.

### DPP Secondary Data Sources

- American Community Survey:** The American Community Survey Samples for Texas will be used to obtain estimates of regional uninsured rates.
- Benchmark data:** The evaluation will leverage ongoing reporting of state benchmarks. Specifically, the THLC online portal will be used to develop evaluation-specific benchmarks, such as CMS core measures, where applicable.
- DPP provider-reported data:** DPP providers must submit data for all measures required by each DPP component during specific reporting periods. For qualitative measures, providers must submit responses that summarize their progress towards implementing those measures. For quantitative measures, providers must submit numerator and denominator totals as specified by HHSC. These data will be used to generate post-DPP implementation measures.
- DSRIP administrative data:** HHSC maintains monitoring and payment information for DSRIP providers to determine incentive valuations and payment amounts earned, and track performance over time. These data will be used to assess changes in incentive payments over time.
- DSRIP provider-reported data:** DSRIP performing providers were required to report their progress on DSRIP reporting categories during specific reporting periods. These data will be used to generate pre-DPP implementation measures, where available.
- HHSC-estimated DPP payment data:** MCOs will provide DPP payments and/or rate enhancements directly to DPP providers. As a result, HHSC will not have direct access to incentive valuations and payment amounts earned.

Instead, HHSC's Managed Care and Actuarial Analysis Unit will use financial data used to develop capitated premium rates to estimate incentive payments made to DPP providers over time. These data are subject to an approximate eighteen-month time lag.

- **Long-stay Minimum Data Set (MDS) data:** Medicare- or Medicaid-certified nursing facilities are required to submit quality measures to CMS quarterly. Results are publicly available on CMS's Care Compare website.<sup>23</sup>
- **Provider-level enrollment data:** HHSC maintains information on Medicaid providers, such as their service location, provider type, and provider specialty. This information will be used to describe providers participating in DPPs.

## DPP Proposed Analytic Methods

The evaluation will leverage both quantitative and qualitative methods under the DPP evaluation component. This section describes the proposed analytic methods for evaluating the DPPs.

## Quantitative Analysis

### Descriptive Statistics

All DPP evaluation measures—except open-ended primary data collection questions—may be examined through a variety of descriptive and inferential statistics. Descriptive statistics include estimates of central tendency and dispersion. Potential inferential analyses include bivariate statistics, parametric tests (e.g., paired or unpaired t-tests), and non-parametric tests (e.g., McNemar's test, Wilcoxon signed-rank test). Importantly, some measures may not be suited to inferential statistics, such as those that rely on population-level data rather than a sample. The external evaluator will ensure the correct application of statistical testing depending on whether the data is population- or sample-based, whether the measure is categorical or continuous, and whether the data meet the assumptions of parametric tests (e.g., normality, independence).

### Descriptive Trend Analysis

Advanced techniques for examining changes over time, such as ITS, are not appropriate due to the limited number of data points available for evaluation of the DPPs. As a result, the evaluation will primarily rely on DTA to examine changes in DPP performance measures over time. DTA plots and analyzes time-series data calculated at equally spaced intervals to explain patterns in selected measures over time. DTA typically focuses on identification and quantification of a trend through the use of correlation coefficients or ordinary least squares regression, if feasible.

To strengthen descriptive statistics and DTA, the DPP evaluation will also leverage benchmarks, where feasible, to help substantiate and contextualize observed trends.

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<sup>23</sup> CMS's Care Compare website is accessible at: <https://data.cms.gov/provider-data/>



## **Qualitative Analysis**

Hypotheses that rely on gathering unstructured provider feedback through primary data collection will be examined using thematic content analysis. This qualitative method involves the identification of patterns and themes within survey or interview data, and is well-suited to analyzing the diverse and nuanced information collected from study participants (Vaismoradi, Turunen, & Bondas, 2013).

## **DPP Methodological Limitations**

Results from the DPP evaluation component will need to be interpreted alongside several limitations. The most salient threat to the internal validity of the evaluation is the potential for confounding factors to influence selected DPP measures. Specifically, DSRIP began a gradual phase-out on October 1, 2019, with measurement reporting concluding at the end of FFY 2021 and payments continuing into early 2023. As a result, DPP providers who participated in DSRIP may receive both DSRIP and DPP incentives during the first year of DPP implementation. Accordingly, conclusions drawn from evaluation measures immediately following DPP implementation may not reflect DPP incentives alone. Additionally, HHSC operates many quality initiatives aimed at improving access and quality under the MMC service delivery model. Some of these quality initiatives target performance measures included in the DPPs. As a result, DPP providers may be subject to multiple incentive structures for improving upon DPP measures. Collectively, while the co-occurring programs or initiatives operating under the Demonstration offer diversified support to Medicaid providers, these confounding factors make it challenging to isolate the impacts of DPPs.

A second limitation of the DPP evaluation component is the reliance on provider reporting. Provider-reported data prior to DPP implementation will not be available for some measures and/or providers, making it difficult to determine whether baseline rates or changes over time differ from the status quo prior to DPP implementation. Historical DSRIP reporting data will be leveraged to obtain pre-DPP implementation data, however this data will only be available for DPP providers who previously participated in DSRIP and reported on the same measures. Further, because HHSC cannot require providers who do not participate in DPPs to report on similar measures, creating a comparison group to determine the extent to which participating providers differ from non-participating providers is not feasible. The lack of a comparison group may make it challenging to assess the generalizability of results to non-participating providers. Additionally, due to the lack of a comparison group, more sophisticated analytic techniques, such as a difference-in-differences, are not possible.

A third limitation of the DPP evaluation component is the one-year approval periods for the new DPPs (CHIRP, DPP BHS, RAPPs, and TIPPS). CMS requires approval for the DPPs annually. At the time of writing, the DPPs are projected to end August 31, 2022. HHSC plans to extend implementation the DPPs for additional demonstration years, but this is contingent on CMS approval. Texas developed the new DPPs to sustain key DSRIP initiative areas and support further delivery system reform after



the expiration of DSRIP. The ability of this evaluation to determine whether the DPPs met their intended purpose is dependent on having sufficient years of DPP data. If CMS does not approve the new DPPs for additional years of implementation, analytic methods and subsequent findings drawn from the DPP evaluation component will be limited.

Lastly, DPPs will be implemented amidst the ongoing COVID-19 pandemic. However, because the COVID-19 pandemic will impact all components of the evaluation, additional details regarding the implications of the pandemic are presented in the larger Methodological Limitations section on page 65.

Despite these limitations, the DPP evaluation component will provide insight into whether DPPs continue the successful innovations of DSRIP, improve health outcomes for Medicaid clients, and support the transformation of Texas Medicaid to a coordinated, quality-based healthcare system.

## SPP Evaluation Methods

A quantitative approach will be used to evaluate two evaluation questions and three hypotheses specific to the UC and PHP-CCP programs. The evaluation questions and hypotheses examine whether SPPs financially support Medicaid providers and the impacts of key policy changes on cost and health outcomes. Two specific lines of inquiry will be pursued to assess key policy changes under this component:

- Did the introduction of the DPPs and the PHP-CCP program mitigate possible hospital financial burden for UC providers by continuing to financially support Medicaid providers following the expiration of DSRIP?
- Did the implementation of UHRIP prior to the transition of the UC program to charity care only mitigate possible hospital financial burden from the transition, resulting in maintenance or improvement in hospital-level performance measures?

## SPP Evaluation Design

The SPP evaluation component will rely on two quasi-experimental designs: a one-group posttest only design and a one-group pretest-posttest design.

- **One-Group Posttest Only Design:** Most measures in the SPP evaluation component will rely on a one-group posttest only design. Measures assessing participating providers or uncompensated care costs (measures under Hypotheses 3.1 and 3.2) rely on application data, and therefore no pretest UC or PHP-CCP program data or comparison group data exist. This design will use consecutive population-based observations of SPP measures to describe changes in costs and payments over time. Measures evaluated through a one-group posttest only design will use descriptive statistics and DTA.
- **One-Group Pretest-Posttest Design:** Measures assessing hospital-based performance measures (measures under Hypothesis 4.1) will be evaluated with a one-group pretest-posttest design. This design will use repeated observations of outcome measures to monitor changes before and after the UC program transitioned to charity care only at the beginning of DY9. Measures evaluated through a one-group pretest-posttest design will use descriptive statistics, DTA, and ITS.

Table 11 and Table 12 provide an overview of all SPP-specific evaluation questions and hypotheses aligned with their respective measures. Subsequent sections provide additional information on the study population, study period, data sources, and analytic methods. Additional details for each of the proposed measures can be found in Appendix E.

**Table 11. Evaluation Design Overview, Evaluation Question 6: Do the SPPs financially support providers serving the Medicaid and uninsured populations?**

<b>Evaluation Hypothesis</b>	<b>Measure(s)</b>	<b>Study Population</b>	<b>Data Source(s) or Data Collection Method(s)</b>	<b>Analytic Methods</b>
<b>H6.1. The UC and PHP-CCP programs financially support Medicaid providers by reimbursing Medicaid or charity care costs in Texas.</b>	6.1.1 Number of UC program providers	<ul style="list-style-type: none"> <li>UC program providers</li> </ul>	<ul style="list-style-type: none"> <li>American Community Survey</li> </ul>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> </ul>
	6.1.2 Number of PHP-CCP program providers	<ul style="list-style-type: none"> <li>PHP-CCP program providers</li> </ul>	<ul style="list-style-type: none"> <li>DSH/UC application</li> </ul>	<ul style="list-style-type: none"> <li>Subgroup analysis<sup>1</sup></li> </ul>
	6.1.3 UC costs and reimbursements		<ul style="list-style-type: none"> <li>PHP-CCP application</li> </ul>	
	6.1.4 PHP-CCP costs and reimbursements		<ul style="list-style-type: none"> <li>Provider-level eligibility files</li> </ul>	
	6.1.5 Perceived successes and challenges of SPPs	<ul style="list-style-type: none"> <li>UC program providers</li> </ul>	<ul style="list-style-type: none"> <li>Provider survey</li> </ul>	<ul style="list-style-type: none"> <li>Thematic content analysis</li> </ul>
	6.1.6 Provider perspectives on state priorities and policy development	<ul style="list-style-type: none"> <li>PHP-CCP program providers</li> </ul>		

Notes. <sup>1</sup> Subgroup analysis will only be performed where applicable. SPP=Supplemental payment program; UC=Uncompensated Care; PHP-CCP=Public Health Provider-Charity Care Pool; DSH=Disproportionate share hospital; DTA=Descriptive trend analysis.

**Table 12. Evaluation Design Overview, Evaluation Question 7: Did the implementation of UHRIP support the hospital delivery system during the transition of the UC program to charity care only?**

<b>Evaluation Hypothesis</b>	<b>Measure(s)</b>	<b>Study Population</b>	<b>Data Source(s) or Data Collection Method(s)</b>	<b>Analytic Methods</b>
<b>H7.1.1. Hospital-based performance measures will maintain or improve following the transition to charity care only in DY9.</b>	7.1.1 Average length of stay per Medicaid inpatient hospital admission	<ul style="list-style-type: none"> <li>Medicaid clients served by UC program providers in UHRIP</li> </ul>	<ul style="list-style-type: none"> <li>CMS HCAHPS® Surveys</li> </ul>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> </ul>
	7.1.2 Average cost per Medicaid inpatient hospital admission	<ul style="list-style-type: none"> <li>Patients served by UC program providers in UHRIP</li> </ul>	<ul style="list-style-type: none"> <li>DSH/UC application</li> <li>EQRO-calculated measures using 3M software</li> </ul>	<ul style="list-style-type: none"> <li>ITS, if feasible</li> <li>Subgroup analysis<sup>1</sup></li> </ul>
	7.1.3 Patients' perceptions of hospital care	<ul style="list-style-type: none"> <li>UC program providers in UHRIP</li> </ul>	<ul style="list-style-type: none"> <li>FFS Claims and MMC Encounters</li> </ul>	
	7.1.4 Potentially preventable complications (3M)	<ul style="list-style-type: none"> <li>UC program providers in UHRIP</li> </ul>	<ul style="list-style-type: none"> <li>Member-level enrollment files</li> </ul>	
	7.1.5 Potentially preventable readmissions (3M)		<ul style="list-style-type: none"> <li>Provider-level eligibility files</li> <li>UHRIP administrative data</li> </ul>	

*Notes.* <sup>1</sup> Subgroup analysis will only be performed where applicable. UHRIP=Uniform Hospital Rate Increase Program; UC=Uncompensated Care; DY=Demonstration year, October 1-September 30; CMS=Centers for Medicare and Medicaid Services; HCAHPS®=Hospital Consumer Assessment of Healthcare Providers and Systems; DSH=Disproportionate share hospital; EQRO=Texas's external quality review organization; FFS=Fee-for-service; MMC=Medicaid managed care; DTA=Descriptive trend analysis; ITS=Interrupted time series.

## SPP Study Populations

The SPP evaluation component includes two study populations: UC program providers and PHP-CCP program providers.

- UC program providers:** UC program providers include hospitals, clinics, and other providers who provide “medical assistance,” as defined in section 1905(a) of the Social Security Act, to individuals who cannot pay for the services received. UC providers included in the evaluation are limited to those who submit an annual Disproportionate Share Hospital (DSH)/UC application. In DY9, there were 527 UC program providers, the majority of which were private hospitals (Table 13); however, the number and distribution of UC program providers may vary from year to year.

**Table 13. UC Program Providers (DY9)**

Provider Type	Count
Ambulance Providers	138
Dental Providers	1
Large Public Hospital	6
Physician Group Practice	16
Private Hospital	253
Small Public Hospital	96
State Hospital	17
Total	527

- UC program providers for Hypothesis 7.1 are limited to those eligible for UHRIP. All hospitals except institutions for mental diseases are eligible for UHRIP. Therefore, Hypothesis 7.1 will be limited to UC large public hospitals, private hospitals, small public hospitals, and state hospitals that are not institutions for mental diseases.
- PHP-CCP program providers:** PHP-CCP program providers are limited to publicly-owned and operated CMHCs, LBHAs, LMHAs, LHDs, and PHDs. Similar to UC program providers, PHP-CCP program providers included in the evaluation are limited to those who submit an annual PHP-CCP application. The PHP-CCP program was not implemented at the time of writing, but HHSC anticipates the program to serve up to 300 providers annually.

## Potential Comparison Groups

Almost all eligible providers participate in the UC program and UHRIP. Since the PHP-CCP program was not implemented at the time of writing, it is unclear whether there is a sufficient number of providers eligible for, but not participating in, the PHP-CCP program to constitute a comparison group. Moreover, the SPP evaluation

component primarily relies on DSH/UC and PHP-CCP applications to obtain cost and payment data; this information is not available for providers not participating in UC or PHP-CCP programs. Thus, in the absence of application data, no viable comparison group exists for the UC or PHP-CCP programs.

## SPP Study Periods

The UC program underwent significant changes at the beginning of DY9 when the program transitioned to a charity care only model (Figure 5). As a result, the focus of the Extension will be on the UC program in DY9 and later.<sup>24</sup> However, hospital-based performance outcomes for UC program providers dating back to DY1 will be used, where applicable, to examine whether the implementation of UHRIP supported hospitals before and after the transition to charity care only at the beginning of DY9. The PHP-CCP program study period will start in DY11 when the program is implemented. The study periods for both the UC and PHP-CCP programs will include payments made through the end of the Extension (DY19). Table 14 details the study periods for the SPP evaluation component.

**Figure 5. SPP Timeline**

DY1	DY2	DY3	DY4	DY5	DY6	DY7	DY8	DY9	DY10	DY11	DY12	DY13	DY14	DY15	DY16	DY17	DY18	DY19
October 1, 2011: Implementation of UC program								October 1, 2019: Transition to charity care only model										
						December 1, 2017: UHRIP pilot begins; expands statewide March 1, 2018 <sup>1</sup>												
						September 1, 2021: Implementation of new DPPs												
						September 30, 2021: DSRIP expires												
													October 1, 2021: Implementation of PHP-CCP program					

*Notes.* <sup>1</sup> Contingent on CMS approval, UHRIP will transition to a component of CHIRP on September 1, 2021. The initial CHIRP approval period extends through August 31, 2022; additional years of implementation contingent on CMS approval. DY=Demonstration year; UC=Uncompensated care; PHP-CCP=Public Health Provider Charity Care Pool.

**Table 14. Study Periods for SPP Evaluation Component**

SPP Hypothesis	Pre-Period	Post-Period
H6.1. The UC and PHP-CCP programs financially support Medicaid providers by reimbursing Medicaid or charity care costs in Texas.	N/A	UC: DY9-DY19 <sup>1</sup> PHP-CCP: DY11-DY19
H7.1. Hospital-based performance measures will maintain or improve following the transition to charity care only in DY9.	DY1-DY8 <sup>2,3</sup>	DY9-DY19 <sup>3</sup>

*Notes.* <sup>1</sup> Trends in UC costs and reimbursements should be explored before and after implementation of the DPPs and the PHP-CCP program in DY11. <sup>2</sup> Not all measures may be available as far back as DY1. The external evaluator will use the earliest data available for each

<sup>24</sup> The Draft Interim Evaluation Report covering DYs 7-11 due to CMS on March 31, 2024 includes an evaluation of the UC program prior to the transition to charity care only.

measure.<sup>3</sup> The external evaluator may utilize multiple pre- or post-periods to capture implementation changes related to UHRIP, if feasible.

UC=Uncompensated Care; PHP-CCP= Public Health Provider Charity Care Pool;

DY=Demonstration year.

## SPP Data Sources

The SPP evaluation component will include both quantitative and qualitative data. These data include both primary and secondary data sources, as outlined below.

### SPP Primary Data Source

- **Provider survey:** The perspectives of providers offer valuable insight about the successes and challenges of SPPs in supporting the operations and sustainability of providers. The external evaluator will determine the most appropriate data collection approach and develop corresponding instruments and/or guides. If feasible, the external evaluator should make efforts to assure primary data collection activities target providers of different types, sizes, and geographic regions to ensure a range of provider perspectives are included. In lieu of a stand-alone survey, the external evaluator may combine primary data collection activities across evaluation components into a single survey.

### SPP Secondary Data Sources

- **American Community Survey:** The evaluation will use estimates of regional characteristics, such as rural-urban continuum codes (RUCC) or uninsured rates, from the American Community Survey Samples for Texas.
- **CMS Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS®) Survey:** The HCAHPS® survey is a standardized national survey of clients' perceptions of hospital care. HCAHPS® assesses areas such as communication with hospital staff, cleanliness of hospital, the discharge process, and an overall rating of the hospital. CMS implemented the survey in 2006 and public reporting began in 2008. HCAHPS® data will be obtained through the CMS public data repository<sup>25</sup> to gather information on clients' experiences with hospitals participating in the UC program. Critical access hospitals and hospitals with less than 250 responses are exempted from the public use data file.
- **DSH/UC application:** UC program providers complete an annual application to apply for reimbursement for costs incurred by providing services to uninsured individuals that are not otherwise reimbursed. Applications are submitted to HHSC annually, but are reimbursed on a two-year lag (e.g., UC payments during DY9 reflect charity care provided during DY7). The UC cost reimbursements are adjusted for inflation as an estimate of the UC costs for the year of payment.

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<sup>25</sup> CMS data repository can be accessed at: <https://data.cms.gov/beta>

- **EQRO-calculated measures using 3M software:** Texas's EQRO (ICHP) uses 3M software to calculate and publish potentially preventable events (PPEs) to the THLC portal. The THLC portal, or similar data obtained directly from ICHP, will be used to produce hospital-level estimates of potentially preventable complications (PPCs) and potentially preventable readmissions (PPRs).
- **FFS claims and MMC encounters:** FFS claims and MMC encounter data have been processed by TMHP since January 1, 2004. TMHP performs internal edits for data quality and completeness. The member-level claims/encounter data contain CPT codes, ICD-10-CM codes, place of service codes, and other information necessary to calculate duration and cost of hospital admissions. There is an approximate eight-month time lag for claims and encounter data adjudication. Prior analyses with Texas data showed that, on average, over 96 percent of the claims and encounters are complete by that timeframe.
- **Member-level enrollment files:** The enrollment files contain information about the person's age, gender, race/ethnicity, county, health care service delivery model (i.e., FFS or MMC), MCO enrollment, and length of enrollment. The member-level enrollment files will be used to identify member-level subgroups for measures related inpatient hospital admissions before and after the transition of UC to charity care only. Member-level enrollment files are subject to an approximate eight-month time lag.
- **PHP-CCP application:** PHP-CCP program providers complete an annual application to be reimbursed for certain costs incurred by providing services that are not otherwise reimbursed. During the first year of PHP-CCP implementation, providers may be reimbursed for charity care and Medicaid shortfall costs. For all other years, PHP-CCP is limited to costs incurred by providing services to uninsured individuals not otherwise reimbursed.
- **Provider-level enrollment files:** Provider-level enrollment files contain information on NPI, TPI, provider location, provider type, and provider specialty. Provider data will be sourced from TMHP and an HHSC SQL database, and are subject to an approximate one-month lag. The provider-level enrollment files will be used to support linking providers across multiple data sources and provide information necessary for any provider-level subgroups.
- **UHRIP administrative data:** HHSC maintains monitoring information for UHRIP to track participating providers and payment amounts over time. These data will be used identify UC program providers who participated in UHRIP.

### SPP Proposed Analytic Methods

Quantitative and qualitative methods will be used to evaluate the SPP evaluation component. This section describes the proposed analytic strategies for examining the measures presented in Table 11 and Table 12.



## **Quantitative Analysis**

### **Descriptive Statistics**

All SPP evaluation measures—except open-ended primary data collection questions—may be examined through a variety of descriptive and inferential statistics. Descriptive statistics include estimates of central tendency and dispersion. Potential inferential analyses include bivariate statistics, parametric tests (e.g., paired or unpaired t-tests), and non-parametric tests (e.g., McNemar's test, Wilcoxon signed-rank test). Importantly, some measures may not be suited to inferential statistics, such as those that rely on population-level data rather than a sample. The external evaluator will ensure the correct application of statistical testing depending on whether the data is population- or sample-based, whether the measure is categorical or continuous, and whether the data meet the assumptions of parametric tests (e.g., normality, independence).

### **Descriptive Trend Analysis**

DTA is an alternative approach to time-series analysis for measures that do not have enough pre-and post-period observations to conduct more rigorous time series analyses, such as ITS. DTA plots and analyzes time-series data calculated at equally spaced intervals to explain patterns in selected measures over time. DTA typically focuses on identification and quantification of a trend through the use of correlation coefficients and ordinary least squares regression.

DTA will be used to examine UC and PHP-CCP costs reimbursed over time (Measures 6.1.3 and 6.1.4), and how cost trends may interact with changes to the Texas Medicaid system, such as the expiration of DSRIP on September 30, 2021. Since the initial approval of the Demonstration, DSRIP has provided vital financial support to Medicaid providers. Without this critical funding, Medicaid providers may be forced to close or curtail Medicaid services. Such disruptions would negatively impact the delivery of care for Medicaid clients and may cause Medicaid beneficiaries and uninsured individuals to rely on hospitals for non-emergent care, thereby increasing overall charity care costs incurred by hospitals. One goal of the DPPs and PHP-CPP programs is to prevent these negative outcomes by extending critical financial support to Medicaid providers. The external evaluator should examine trends in uncompensated charity care costs reimbursed on either side of the transition from DSRIP to the DPPs and PHP-CCP program (September/October 2021) to determine whether implementation of these programs helped to stabilize the Medicaid system and mitigate possible increases in uncompensated charity care costs following the expiration of DSRIP.

DTA will also be used to examine hospital-based performance measures (7.1.1 to 7.1.5) before and after the UC program transitioned to charity care only in DY9 if the recommended minimum number of observations for ITS are not available (i.e., eight pre- and eight post-Demonstration time points).

## Interrupted Time Series

ITS analysis uses aggregate data collected over equally spaced intervals before and after a policy change. A key assumption of ITS is that data trends before the policy change can be extrapolated to predict trends had the policy change not occurred. If a policy change has an impact on an outcome of interest, the trend of that outcome will have a slope that is significantly different from the slope before the policy change.

When properly executed, ITS is a valuable method to evaluate the success, failure, or unintended consequences of health care policy on outcomes (Lagarde, 2012). However, given the serial nature of ITS data, autocorrelation, nonstationarity, and seasonality need to be considered. Failing to assess and correct for these factors can lead to biased results (Wagner, Soumerai, Zhang, & Ross-Degnan, 2002). A key strength of ITS methodology is that a control site is not required, providing an alternate method of measuring the effect of an intervention “when randomization or identification of a comparison group are impractical” (Grimshaw, et al., 2003). The ITS method allows the target population to serve as its own comparison group.

An ITS model will be used to evaluate measures under Hypothesis 7.1. For Hypothesis 7.1, a basic segmented regression model will examine a series of hospital-based performance measures (7.1.1 to 7.1.5) before and after the UC program transitioned to charity care only in DY9. The proposed regression model for each outcome of interest ( $Y_t$ ) over time is:

$$Y_t = \beta_0 + \beta_1(\text{time}) + \beta_2(\text{UC transition}_t) + \beta_3(\text{post time}_t) + \varepsilon_t$$

In the above equation,  $\beta_0$  represents the baseline level of the outcome measure at the beginning of the study period;  $\beta_1$  estimates trends in the outcome measure before the transition to charity care only;  $\beta_2$  estimates the immediate impact of the transition to charity care only; and  $\beta_3$  estimates the change in trend of the outcome measure after the transition to charity care only. To ease interpretation, ITS results are presented as: baseline level, trend before transition to charity care only, level change after transition to charity care only, and trend after transition to charity care only.

The ITS model for Hypothesis 7.1 will incorporate subgroup analyses (e.g., by provider type or RUCC classification), where feasible, to strengthen the validity of observed outcomes.

## Qualitative Analysis

Hypotheses that rely on gathering unstructured provider feedback through primary data collection will be examined using thematic content analysis. This qualitative method involves the identification of patterns and themes within survey or interview data, and is well-suited to analyzing the diverse and nuanced information collected from study participants (Vaismoradi, Turunen, & Bondas, 2013).

## **SPP Methodological Limitations**

A major limitation of the SPP evaluation component is the use of application data. These data were designed for administrative payment purposes, not for research. As a result, the information is limited to what is required to be paid through the UC or PHP-CCP programs. These data do not include information on charity care costs prior to DY9, and do not include payer source or other subgroupings that would allow evaluators to determine the source of uncompensated care. Additionally, the use of application data means that uncompensated care cannot be estimated before the UC or PHP-CCP programs were implemented. This limitation is especially salient for the UC program, which transitioned to charity care only in DY9. DSH/UC applications prior to DY9 did not require providers to submit charity care costs like those submitted after DY9, limiting examinations into changes in charity care prior to DY9.

The use of application data also means the SPP evaluation component is limited by the lack of a comparison group. Subgroup analyses and rigorous one-group analytic methods will be utilized, where applicable. However, the lack of a comparison group makes it difficult to draw causal inferences about the impact of these programs. A final limitation associated with the use of application data is data lags, which pose a challenge to measuring and reporting changes in a timely manner (Schoenberg, Heider, Rosenthal, Schwartz, & Kaye, 2015). The UC program is subject to a two-year data lag.

Analyses of certain hospital-level outcome measures for the UC program before and after the transition to charity care only in DY9 are limited by the use of all-payer data. Specifically, PPEs and patients' perceptions of hospital care are not restricted to individuals whose care was eventually reimbursed through the UC program. Rather, these measures include both uninsured individuals and individuals with public or private insurance. Stronger hospital financial performance, including less uncompensated care or accounts receivable, has been associated with greater hospital quality, safety, and patient experience of care (Akinleye, McNutt, Lazariu, & McLaughlin, 2019). While the use of all-payer data will allow the evaluation to measure changes in hospital-level outcomes over the study period, it may be difficult to detect more nuanced impacts to specific payer groups resulting from the implementation of UHRIP or programmatic changes in the UC program itself.

Lastly, the COVID-19 pandemic began in the middle of DY9 when UC transitioned to charity care only. Additionally, the PHP-CCP program is slated to be implemented amidst the ongoing COVID-19 pandemic. Impacts of these policy changes will be confounded by impacts to uncompensated care costs resulting from the COVID-19 pandemic. However, since the COVID-19 pandemic will impact all evaluation components, additional details regarding the implications of the pandemic are presented in the larger Methodological Limitations section on page 65.

Despite these limitations, the SPP evaluation component will provide insight into how UC and PHP-CCP programs support providers, changes in uncompensated care

costs over time, and impacts to hospital-level outcomes following the transition to charity care only. This evaluation component will inform whether Texas has made progress towards improved outcomes while containing cost growth.

## **Overall Demonstration Evaluation Methods**

The Overall Demonstration evaluation component will utilize a mixed-method approach to investigate three evaluation questions and four hypotheses related to cost outcomes for the Demonstration as a whole. The Overall Demonstration evaluation component explores Medicaid health service expenditures and the administrative costs associated with implementing and operating the Demonstration; in addition, this section considers how Demonstration costs align with other Demonstration components to support provider operations and sustainability.

## **Overall Demonstration Evaluation Design**

The Overall Demonstration evaluation component will rely on one quasi-experimental design: a one-group posttest only design. This design will use repeated observations of cost measures across all Demonstration approval periods (DY1 to DY19). Measures will be evaluated use descriptive statistics and DTA.

Table 15, Table 16, and Table 17 provide an overview of Overall Demonstration-specific hypotheses aligned with their respective measures. Subsequent sections provide additional information on the study populations, study periods, data sources, and analytic methods. Additional details for each of the proposed measures can be found in Appendix E.

**Table 15. Evaluation Design Overview, Evaluation Question 8: What are the costs of providing health care services to Medicaid beneficiaries served under the Demonstration?**

<b>Evaluation Hypothesis</b>	<b>Measure(s)</b>	<b>Study Population</b>	<b>Data Source(s) or Data Collection Method(s)</b>	<b>Analytic Methods</b>
<b>H8.1. The Demonstration results in overall savings in health care service expenditures.</b>	8.1.1 Actual Medicaid health service expenditures	<ul style="list-style-type: none"> <li>Medicaid Eligibility Groups served under the Demonstration</li> </ul>	<ul style="list-style-type: none"> <li>Budget neutrality worksheet</li> </ul>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> </ul>
	8.1.2 Hypothetical WOW Medicaid health service expenditures			

Notes. WOW=Without waiver; DTA=Descriptive trend analysis.

**Table 16. Evaluation Design Overview, Evaluation Question 9: What are the administrative costs of implementing and operating the Demonstration?**

<b>Evaluation Hypothesis</b>	<b>Measure(s)</b>	<b>Study Population</b>	<b>Data Source(s) or Data Collection Method(s)</b>	<b>Analytic Methods</b>
<b>H9.1. Administrative costs required to implement and operate the Demonstration are relatively stable and reasonable over time.</b>	9.1.1 HHSC administrative costs directly attributable to the Demonstration	<ul style="list-style-type: none"> <li>HHSC</li> </ul>	<ul style="list-style-type: none"> <li>Form CMS-64</li> </ul>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> </ul>
	9.1.2 MCO administrative costs		<ul style="list-style-type: none"> <li>MCO Financial Statistical Reports</li> </ul>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> </ul>

Notes. HHSC=Health and Human Services Commission; CMS=Centers for Medicare and Medicaid Services; DTA=Descriptive trend analysis; MCO=Managed care organization.

**Table 17. Evaluation Design Overview, Evaluation Question 10: How do the funding pools administered through the Demonstration support providers and overall Medicaid program sustainability?**

<b>Evaluation Hypothesis</b>	<b>Measure(s)</b>	<b>Study Population</b>	<b>Data Source(s) or Data Collection Method(s)</b>	<b>Analytic Methods</b>
<b>H10.1. The Demonstration leverages savings in health care service expenditures to administer quality-based payment systems and supplemental funding pools.</b>	<p>10.1.1 Total expenditures for DSRIP, DPPs, and SPPs</p> <p>10.1.2 Medicaid providers receiving payments through DSRIP, DPPs, and SPPs</p>	<ul style="list-style-type: none"> <li>• DPP providers</li> <li>• DSRIP providers</li> <li>• PHP-CCP program providers</li> <li>• UC program providers</li> </ul>	<ul style="list-style-type: none"> <li>• Budget neutrality worksheet</li> <li>• DSRIP and DPP administrative data</li> <li>• DSH/UC application</li> <li>• PHP-CCP application</li> </ul>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>H10.2. The quality-based payment systems and supplemental funding pools administered through the Demonstration support Medicaid provider operations and sustainability.</b>	<p>10.2.1 Perceived successes and challenges of DPPs and SPPs</p> <p>10.2.2 Provider perspectives on state priorities and policy development</p>	<ul style="list-style-type: none"> <li>• DPP providers</li> <li>• PHP-CCP program providers</li> <li>• UC program providers</li> </ul>	<ul style="list-style-type: none"> <li>• Provider survey</li> </ul>	<ul style="list-style-type: none"> <li>• Thematic content analysis</li> </ul>

*Notes.* DSRIP=Delivery System Reform Incentive Payment; DPP=Directed payment program; SPP=Supplemental payment program; PHP-CCP=Public Health Providers Charity Care Pool; UC=Uncompensated Care; DSH=Disproportionate share hospital.

## Overall Demonstration Study Populations

The study population for the Overall Demonstration evaluation component collectively refers to all stakeholders, providers, members, and individuals contributing to and/or being served through the Demonstration. However, costs are presented for four study populations:

- **Medicaid Eligibility Groups (MEGs) served under the Demonstration:** The MEGs reflect state plan eligibility groups that are mandatory and voluntary enrollees in MMC (i.e., beneficiaries served through the Demonstration). MEGs are categorized into four groups for the purposes of budget neutrality limit calculations:<sup>26</sup>
  - **Adults:** Medicaid assistance expenditures for low-income parent and caretaker relatives, pregnant women, family members providing permanent homes for children who were in foster care, and individuals who aged out of foster care.
  - **Children:** Medicaid assistance expenditures for infants, children, and transitional youth in low-income families, and individuals who aged out of foster care.
  - **Aged and Medicare Related:** Medicaid assistance expenditures for children and adults receiving SSI benefits, Dual eligibles (Medicare and Medicaid), children with disabilities with Medicaid buy-in, individuals residing in a nursing facility, and individuals needing treatment for breast or cervical cancer.
  - **Disabled:** Medicaid assistance expenditures for children and adults receiving SSI benefits and/or with disabilities who are not receiving Medicare.
- **HHSC:** HHSC staff and contractors involved in the administration and operation of the Demonstration.
- **MCOs:** MCOs contracted to administer STAR, STAR+PLUS, and STAR Kids MMC Programs.

## Potential Comparison Groups

The Demonstration operates statewide and encompasses almost all individuals served through MMC.<sup>27</sup> In addition, nearly all eligible providers have historically participated in the quality-based payment systems and supplemental funding pools administered through the Demonstration. Collectively, this means there is no characteristically similar group of individuals or providers not involved in Demonstration activities, and therefore, no available comparison group for the Demonstration as a whole.

<sup>26</sup> STC 18 provides additional details on eligibility groups served through the Demonstration.

<sup>27</sup> STAR Health is an MMC program that operates outside the Demonstration. STAR Health is limited to children in conservatorship, in the Adoption Assistance or Permanency Care Assistance program, extended foster care, or Former Foster Care Children.



However, the Overall Demonstration evaluation component relies on hypothetical health care service expenditures ('Without Waiver' [WOW] expenditures) to estimate costs for individuals served under the Demonstration if the Demonstration did not exist (i.e., a hypothetical comparison group). These WOW expenditures are created for budget neutrality purposes and reflect theoretical costs for MEGs served under the Demonstration if their services were provided through FFS instead of MMC. The WOW expenditures are available for each DY.

## Overall Demonstration Study Periods

The Overall Demonstration evaluation component will rely on costs (expenditures and payments) under the Demonstration (post-Demonstration) and will span all Demonstration approval periods (DY1 through DY19).

## Overall Demonstration Data Sources

The Overall Demonstration evaluation component will include both quantitative and qualitative data. These data include both primary and secondary data sources, as outlined below.

### Overall Demonstration Primary Data Source

- **Provider survey:** Both the DPP and SPP evaluation components include primary data collection to gain insights into the how these programs support the operation and sustainability of providers. The Overall Demonstration evaluation component will leverage combined results from the provider surveys in the DPP and SPP evaluation components to provide a holistic description of how the Demonstration supports Medicaid providers.

### Overall Demonstration Secondary Data Sources

- **Budget neutrality worksheet:** HHSC and CMS collaborate to determine the total cost of the Demonstration. "With waiver" (WW) costs are calculated for all years of the Demonstration, with past years based on actual costs and future years projected based on forecasted spending and enrollment trends. WOW costs are projections based on what the services provided would cost without the Demonstration. HHSC submits the budget neutrality worksheet to CMS quarterly, and also produces an annual budget neutrality summary. The quarterly budget neutrality worksheet relies exclusively on actual costs, whereas the annual summary uses cost caps for SPPs and DPPs.<sup>28</sup> Quarterly budget neutrality worksheets and annual summaries will be provided to the external evaluator.
- **DSH/UC application:** UC program providers complete an annual application to apply for reimbursement for costs incurred by providing services to uninsured individuals that are not otherwise reimbursed. Applications are

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<sup>28</sup> The annual budget neutrality worksheet also relies on historical costs for DPPs.



submitted to HHSC annually, but are reimbursed on a two-year lag (e.g., UC payments during DY9 reflect charity care provided during DY7). The UC cost reimbursements are adjusted for inflation as an estimate of the UC costs for the year of payment. These data will be used to examine Medicaid providers participating in funding pools administered through the Demonstration.

- **DSRIP and DPP administrative data:** HHSC maintains monitoring information for DSRIP and DPP providers to track program participation over time. These data will be used to examine Medicaid providers participating in payment incentive programs administered through the Demonstration.
- **Form CMS-64:** Form CMS-64 is part of the Medicaid Budget and Expenditure System, a web-based application used to obtain quarterly expenses to compute the Federal Financial Participation amount CMS provides to states. Form CMS-64 includes a variety of sections detailing different types of expenditures. The Overall Demonstration evaluation component will focus on 64.10 expenditures for state and local administration attributable to the Demonstration. These administrative expenditures include costs associated with the Medicaid Management Information System, preadmission screening costs, enrollment brokers, and all other costs necessary to administer the Demonstration, including staff time and contracts management.
- **MCO Financial Statistical Reports (FSRs):** All MCOs contracted to provide MMC in Texas are required to submit FSRs for each service area and MMC program they operate. FSRs include a variety of financial information from MCOs, including revenues and expenditures for MMC members in the service area. The Overall Demonstration evaluation component will focus on MCO administrative expenses such as staff time, office space, equipment, and supplies.
- **PHP-CCP application:** PHP-CCP program providers complete an annual application to be reimbursed for certain costs incurred by providing services that are not otherwise reimbursed. During the first year of PHP-CCP implementation, providers may be reimbursed for charity care and Medicaid shortfall costs. For all other years, PHP-CCP is limited to costs incurred by providing services to uninsured individuals not otherwise reimbursed. These data will be used examine Medicaid providers participating in funding pools administered through the Demonstration.

## Overall Demonstration Proposed Analytic Methods

Quantitative and qualitative methods will be used for the Overall Demonstration evaluation component. This section describes the proposed analytic strategies for examining the measures presented in Table 15, Table 16, and Table 17. Analytic methods will incorporate subgroup analyses (e.g., by provider type or region), where feasible, to strengthen the validity of observed outcomes.

## **Quantitative Analysis**

### **Descriptive Statistics**

All Overall Demonstration evaluation measures—except open-ended primary data collection questions—may be examined through a variety of descriptive and inferential statistics. Descriptive statistics include estimates of central tendency and dispersion. Potential inferential analyses include bivariate statistics, parametric tests (e.g., paired or unpaired t-tests), and non-parametric tests (e.g., McNemar's test, Wilcoxon signed-rank test). Importantly, some measures may not be suited to inferential statistics, such as those that rely on population-level data rather than a sample. The external evaluator will ensure the correct application of statistical testing depending on whether the data is population- or sample-based, whether the measure is categorical or continuous, and whether the data meet the assumptions of parametric tests (e.g., normality, independence).

### **Descriptive Trend Analysis**

The costs included in the Overall Demonstration evaluation component exist only under the Demonstration. As a result, preferred time-series designs such as ITS are infeasible. DTA is an alternative approach to time-series analysis for programs that do not have an intervention point in the time series. DTA plots and analyzes time-series data calculated at equally spaced intervals to explain patterns in selected measures over time. DTA typically focuses on identification and quantification of a trend through the use of correlation coefficients and ordinary least squares regression. DTA will be used for all Overall Demonstration evaluation measures—except open-ended primary data collection questions.

## **Qualitative Analysis**

Hypotheses that rely on unstructured provider feedback obtained through DPP and SPP primary data collection surveys will be examined using thematic content analysis. Thematic content analysis identifies and codes patterns or themes in the data using inductive or deducting reasoning (Vaismoradi, Turunen, & Bondas, 2013). Thematic content analysis will be used to describe provider feedback related to how provider payment incentives and funding pools support provider operations and sustainability. A strength of thematic content analysis is its ability to examine similarities and differences in the perspectives of study participants (Nowell, Norris, White, & Moules, 2017), such as the differences between DPP and SPP providers, or providers participating in multiple programs.

## **Overall Demonstration Methodological Limitations**

There are several limitations the Overall Demonstration evaluation component. First, given the long-standing, statewide nature of the Demonstration, no existing comparison groups are available for estimating a counterfactual condition without the Demonstration. Historical health care expenditures may be used as contextual reference, but due to differences in individuals included in historical health care expenditures and those served under the Demonstration, these historical costs

cannot be used to determine costs which would have been incurred in the absence of the Demonstration.

Another limitation of the Overall Demonstration evaluation component is the reliance on application data and federally-and state-mandated reporting. These data were designed for administrative and oversight purposes, not for research. As a result, analyses are limited to what is available through these data sources. These data include health care service expenditures derived from FFS claims and MMC encounters data, administrative costs, and payments to providers necessary to investigate cost outcomes for the Demonstration as a whole; however, these data may not represent all possible costs associated with the Demonstration and may only be available at the aggregate level.

Lastly, study periods for the Overall Demonstration evaluation component span the COVID-19 pandemic. Since the COVID-19 pandemic will impact all evaluation components, additional details regarding the implications of the pandemic are presented in the larger Methodological Limitations section on page 65.

Despite these limitations, the Overall Demonstration evaluation component will provide insight into cost outcomes for the Demonstration as a whole, including health care service expenditures and administrative costs, how the Demonstration leverages cost savings into provider payment incentives and funding pools, and ultimately, how the Demonstration supports Medicaid provider operations and sustainability.

## 4. Special Methodological Considerations

The Demonstration aims to transform the Medicaid healthcare delivery system in Texas through the expansion of risk-based managed care and quality-based payment systems that target improved care coordination and health outcomes while containing overall cost growth. To meet these goals, the Demonstration contains multiple components. The complex, statewide nature of the Demonstration presents challenges for the evaluation of the Extension. Many demonstration components are pervasive in reach, including nearly all Medicaid clients or eligible providers that meet program criteria. Additionally, components of the Demonstration were implemented at different times, and each component comes with ongoing policy changes such as funding pool resizing, the initiation of new services, and the incorporation of new populations. Differences in timing and implementation of these components make it difficult to establish consistent definitions and isolate effects over time. Moreover, many providers and clients participate in multiple Demonstration components simultaneously; for example, many hospitals participate in the delivery of managed care, DSRIP, UHRIP/CHIRP, and UC, effectively spanning the entire slate of Demonstration activities. Over time, the Demonstration has become increasingly intertwined with the broader operations of Texas Medicaid and its array of quality initiatives and satellite programs.

At the time of writing, the Demonstration was in the tenth year of operation. The long-standing nature of the Demonstration also poses unique challenges to the evaluation of the Extension because evaluation pre-periods are no longer free of relevant interventions. In the proposed evaluation design, new or modified Demonstration components are primarily compared to outcomes derived from prior Demonstration periods, not a historical cohort free from the Demonstration. Additionally, the statewide implementation of the Demonstration precludes the availability of a true comparison group. The implementation of new components or shifts in component operations apply to all eligible Medicaid members or providers. Members or providers who do not experience the change would either represent different eligibility groups or differences in motivation or engagement (i.e., selection bias). The lack of a true historical or contemporary comparison group is problematic for identifying a counterfactual condition that would allow the external evaluator to attribute changes in evaluation measures to specific Demonstration components. The evaluation design plan incorporates rigorous mixed-methods quasi-experimental evaluation designs to compensate for the absence of a true counterfactual. Results from the evaluation will provide insight into whether the state continued making progress towards the goals set forth in the initial Demonstration and met the specific aims of the Extension. However, evaluation results from specific Demonstration components may not imply direct causality; instead, evaluation results should be considered in aggregate when assessing the Demonstration performance.

The Demonstration evaluation will also coincide with additional programmatic changes to Texas Medicaid, such as the state's other 1115 Demonstration Waiver for the Healthy Texas Women program, and updates to the Managed Care Quality Strategy, which Texas will revise no less than every three years. Texas will also undergo five legislative sessions during the Extension, which may significantly alter the Medicaid landscape operating both under and outside the Demonstration. The multiple, ongoing state efforts to improve the administration of Texas Medicaid adds further complexity to the interpretation of evaluation findings.

Finally, it should be noted that this evaluation design is being written during the ongoing COVID-19 pandemic. The outbreak has reordered priorities for both clients and providers in the state. One immediate consequence of the pandemic was to depress Medicaid utilization due to social distancing measures and shifting health care concerns. Medicaid enrollment was also impacted as the state implemented temporary eligibility changes to Medicaid programs in response to the pandemic. The COVID-19 pandemic is a confounding factor that may undermine casual inference of evaluation results across multiple domains. The external evaluator will take care to present pertinent findings within the appropriate context, and adjust the evaluation, where applicable and feasible, such that findings reflect the effects of 1115 Demonstration policies.

## 5. Communication, Dissemination, and Reporting

The Interim and Summative Evaluation Reports will be produced in alignment with the Attachment P of the Special Terms and Conditions (STCs), *Preparing the Evaluation Report*, and the schedule of deliverables listed in the timeline (Table 18 on the following page).

### State Presentations for the CMS

As specified in STC 89, if requested by CMS, Texas will present and participate in discussions with CMS regarding the Evaluation Design, Interim Evaluation, and/or the Summative Evaluation Reports.

### Public Access

As specified in STC 90, Texas shall post final documents (e.g., Monitoring Reports, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 days of approval by CMS.

### Additional Publications and Presentations

Attachment O to the STCs, *Developing the Evaluation Design*, endorses dissemination of 1115(a) Demonstration evaluation findings on "what is or is not working and why." As a result, presentation of evaluation reports or their findings are encouraged. However, as specified in STC 91, for a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (e.g., journal articles), by the state, contractor, or any other third party directly connected to the demonstration, including any associated press materials. Additionally, all peer-reviewed and non-peer-reviewed publications and presentations will be listed as an appendix in the Interim and Summative Evaluation Reports.

**Table 18. Schedule of Evaluation Deliverables**

<b>Deliverable</b>	<b>Date</b>
STCs approved for the 1115(a) the Extension	January 15, 2021
HHSC submits Draft Evaluation Design Plan to CMS for comments (within 180 calendar days of Extension approval)	July 14, 2021
<i>HHSC receives comments from CMS (estimated within 90 calendar days)</i>	<i>October 12, 2021</i>
HHSC submits revised Evaluation Design (within 60 calendar days of receipt of CMS comments) and posts to the state's Demonstration website <sup>1</sup>	December 11, 2021
<i>CMS approves Evaluation Design (estimated within 90 calendar days)</i>	<i>March 11, 2022</i>
HHSC procures an independent evaluator (estimated within 1 year from the date of CMS approval of Evaluation Design) <sup>1</sup>	March 11, 2023
HHSC submits Draft Interim Evaluation Report for DYs 7-11 to CMS for comment	March 31, 2024
<i>HHSC receives comments from CMS (estimated within 90 business days)</i>	<i>June 29, 2024</i>
HHSC submits Final Interim Evaluation Report for DYs 7-11 to CMS (within 60 calendar days of receipt of comments) <sup>1</sup>	August 28, 2024
HHSC submits Draft Interim Evaluation Report for DYs 10-14 to CMS for comment	March 31, 2027
<i>HHSC receives comments from CMS (estimated within 90 business days)</i>	<i>June 29, 2027</i>
HHSC submits Final Interim Evaluation Report for DYs 10-14 to CMS (within 60 calendar days of receipt of comments) <sup>1</sup>	August 28, 2027
HHSC submits Draft Interim Evaluation Report for DYs 10-16 to CMS for comment	September 30, 2029
<i>HHSC receives comments from CMS (estimated within 90 business days)</i>	<i>December 29, 2029</i>
HHSC submits Final Interim Evaluation Report for DYs 10-16 to CMS (within 60 calendar days of receipt of comments) <sup>1</sup>	February 27, 2030
HHSC submits Draft Summative Evaluation Report for DYs 10-19 to CMS for comment	March 30, 2032
<i>HHSC receives comments from CMS (estimated within 90 business days)</i>	<i>June 28, 2032</i>
HHSC submits Final Evaluation Report to CMS (within 60 calendar days of receipt of comments) <sup>1</sup>	August 27, 2032

Notes. <sup>1</sup> Evaluation deliverable date may require adjustments depending on when HHSC receives CMS comments on initial drafts. STC=Special Terms and Conditions; HHSC=Health and Human Services Commission; CMS=Centers for Medicare and Medicaid Services; DY=Demonstration year.

## Appendix A. Document History Log

**Table 19. Document History Log**

<b>Status<sup>1</sup></b>	<b>Document Revision<sup>2</sup></b>	<b>Effective Date</b>	<b>Description<sup>3</sup></b>
Baseline	n/a	July 14, 2021	Draft Evaluation Design for the Extension (STC 82)

*Notes.* STC=Special Terms and Conditions; CMS=Centers for Medicare and Medicaid Services.

<sup>1</sup> Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions.

<sup>2</sup> Revisions should be numbered according to the version of the issuance and sequential number of the revision - e.g., "1.2" refers to the first version of the document and the second revision.

<sup>3</sup> Brief description of the changes to the document made in the revision.



## **Appendix B. Independent Evaluator**

The STCs state the Demonstration evaluation must be conducted by an independent evaluator. To meet this requirement, HHSC will identify and contract with an independent external evaluator.

### **External Independent Evaluator**

#### **Required Qualifications**

HHSC will select an independent evaluator with the expertise, experience, and impartiality to conduct a scientifically rigorous program evaluation meeting all requirements specified in the STCs, including the skills needed to examine measures in Appendix E, and meet deadlines in Table 18 (Schedule of Evaluation Deliverables). Required qualifications and experience include multi-disciplinary health services research skills and experience; an understanding of and experience with the Medicaid program; familiarity with HHSC programs and populations; and experience conducting complex, multi-faced evaluations of large, multi-site health and/or social services programs.

Potential external evaluators will be assessed on their relevant work experience, staff expertise, data management and analytic capacity, experience working with state agency program and research staff, proposed resource levels and availability of key staff, track record of related publications in peer-reviewed journals, and the overall quality of their proposal. Proposed deliverables must meet all standards of leading academic institutions and academic journal peer review. In the process of identifying, selecting, and contracting with an independent external evaluator, Texas will act appropriately to prevent a conflict of interest with the independent external evaluator, including the requirement to sign a declaration of "No Conflict of Interest."

HHSC will pursue a contract to secure independent evaluation services from a Texas university. The contracting process includes development of a project proposal and quote request specifying the Scope of Work, vendor qualifications, vendor requirements, timelines, milestones, and cost estimate template. The cost estimate template will include a breakdown of costs for staffing, fringe benefit, travel, equipment and supplies, data collection, and other administrative and indirect costs. The project proposal and quote request will be sent to the list of Texas universities allowing approximately 30 calendar days for response. A team of reviewers at HHSC will be identified prior to the submission deadline for proposals. Each proposal submitted in response to the request will be reviewed by the HHSC team of reviewers. Respondents with the best proposal and value are identified by the team. HHSC will make a final decision for contract award based on the strength of the overall proposal and the abilities of the external evaluator to satisfy the requirements of the project proposal and quote request and conduct the

independent evaluation in the timeframe required. The contracting process begins once a university is selected.

The timeframe for soliciting and contracting with an independent evaluator is 6-12 months from the date an Evaluation Design Plan is approved by CMS.

## Evaluation Budget

As required by CMS in Attachment O of the STCs, Section F(2), the independent evaluator's budget for implementing the evaluation will include total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. The total budget for the external independent evaluator is estimated to be approximately \$12 million for ten years (March 11, 2023 through September 30, 2032),<sup>29</sup> but the final budget will not be available until the external evaluator is selected. The estimated budget amount will cover all evaluation expenses, including salary, fringe, administrative costs, other direct costs such as travel for data collection, conference calls, as well as indirect costs and those related to quantitative and qualitative data collection and analysis, and report development. As part of the contracting process, potential contractors will populate the budget shell (Table 20).

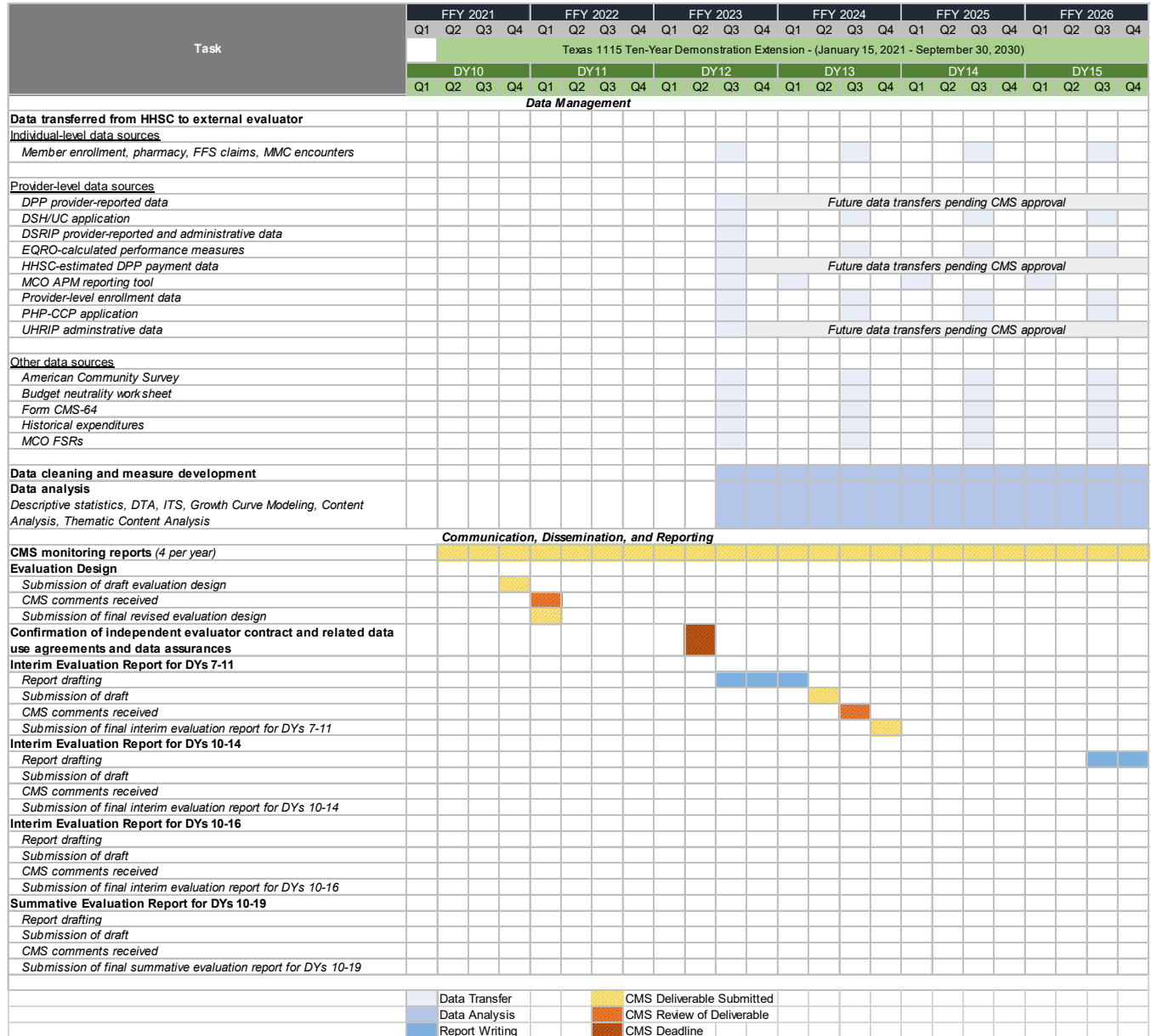
**Table 20. Proposed Evaluation Budget**

Category	Total Cost
Personnel	
Fringe	
Travel	
Indirect Costs	
Data Collection	
Equipment/Supplies	
Other Administrative Costs	
TOTAL EVALUATION COST	

<sup>29</sup> The external evaluator timeframe, March 11, 2023 through September 30, 2032, begins on the date HHSC will execute the contract with an external evaluator and extends through CMS approval of the Summative Evaluation Report, allowing time for external evaluators to address any CMS comments/questions. The external evaluation contract end date may be extended based on when HHSC receives CMS comments on the Draft Summative Evaluation Report.

## Evaluation Timeline and Major Milestones

**Figure 6. Estimated Evaluation Timeline and Major Milestones**



73

## **Appendix C. HHSC Quality Initiative Descriptions**

This appendix outlines the primary HHSC quality initiatives in place at the time of writing. HHSC quality initiatives are designed to incentivize and compare MCO, provider, and hospital performance across key process and outcome performance measures to improve the overall MMC service delivery model as specified in the state's managed care quality strategy.

**Administrative Interviews:** In accordance with 42 CFR 438.358, the EQRO conducts administrative interviews with each plan in Medicaid/CHIP, within a three-year period, to assess MCO/DMO compliance with state standards for access to care, structure and operations, and quality assessment and performance improvement (QAPI). The administrative interview process consists of four main deliverables, namely an Administrative Interview (AI) tool, AI evaluations, onsite visits, and AI reports.

**Core Measure Reporting:** Each year, CMS publishes Adult and Children Health Care Quality Core Set of measures to track quality of care and health care outcomes for Medicaid and CHIP beneficiaries. States voluntarily report on Adult and Children Health Care Quality Core Set measures to CMS. The EQRO assists HHSC in reporting core measures to CMS each year.<sup>30</sup>

**Dental P4Q Program:** The Dental P4Q Program was implemented in 2014 and redesigned in 2018. The Dental P4Q program puts 1.5 percent of each dental plan's capitation at risk of recoupment based on performance measures. If dental plan performance declines beyond a set threshold for the Dental P4Q measures, HHSC will recoup 1.5 percent of the capitation. If dental plan performance falls within a "neutral zone" for Dental P4Q measures, they will not face recoupment or distribution of additional funds. If dental plan performance improves beyond a set threshold for the Dental P4Q measures, the plan will receive their full capitation rate and may be eligible for additional distribution of funds, contingent on funding availability.

**Directed Payment Programs:** HHSC has operated DPPs since the implementation of DSRIP projects in 2013. Other DPPs include QIPP implementation in 2017, state-wide implementation of UHRIP in 2018, and four new DPPs scheduled to begin in 2021. While the focus of each DPP may differ, the shared goal is to incentivize quality and innovation of services.

**Hospital Quality-Based Payment Program:** The Hospital Quality-Based Payment Program was implemented in SFY 2013. As part of this program, HHSC collects data on some PPEs and uses these data to improve quality and efficiency. MCOs and hospitals are fiscally accountable for PPCs and PPRs flagged by HHS. Based on

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<sup>30</sup> CMS Core Set measure results are accessible via: <https://thlcportal.com/measures/cmscoremeasuredashboard>

performance on these measures, adjustments may be made to each MCO's capitation rates and to hospitals' FFS reimbursements.

**MCO Report Cards:** HHSC implemented MCO Report Cards in 2014. HHSC develops annual reports cards for each STAR, CHIP, STAR+PLUS, and STAR Kids MCO. The reports cards are provided at the service area level to allow Medicaid beneficiaries to compare MCOs on specific quality measures before enrolling in a plan. MCO report cards are posted on HHSC's website and included in Medicaid enrollment packets sent to potential members.

**MCO Requirements for Value-Based Contracting:** HHSC began assessing the payment methodologies MCOs use with their providers in 2012 and added a contract provision requiring MCOs to implement VBP models in 2014. HHSC established four-year targets for MCOs in 2018. The 2018 target required 25 percent of MCO payments to be associated with APMs, and 10 percent of MCO payments to be associated with APMs in which providers accept some level of risk. The 2021 target required 50 percent of MCO payments to be associated with APMs, and 25 percent of MCO payments to be associated with APMs in which providers accept some level of risk. MCOs failing to meet minimum APM targets are required to submit a corrective action plan and may be subject to additional contractual remedies, including liquidated damages.

**Medical Pay-for-Quality (P4Q) Program:** The Medical P4Q Program was implemented in 2014 and redesigned in 2018. The Medical P4Q program creates incentives and disincentives for all MCOs based on their performance on certain quality measures. Health plans that excel at meeting the at-risk measures and bonus measures may be eligible for additional funds, while health plans that do not meet their at-risk measures can have up to three percent of their capitation payments for the measurement year recouped.

**Medicaid Value-Based Enrollment:** HHSC began using value scores in the auto-enrollment for MCOs participating in STAR, STAR+PLUS, and STAR Kids in 2020. The value score will automatically enroll a greater proportion of Medicaid beneficiaries who have not selected a health plan into MCOs with higher quality of care, efficiency, and effectiveness of service provision and performance.

**Performance Improvement Projects:** The Balanced Budget Act of 1997 requires all states with Medicaid managed care to ensure MCOs conduct Performance Improvement Projects (PIPs). 42 CFR 438.330 requires projects be designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical care and nonclinical care areas that have a favorable effect on health outcomes and enrollee satisfaction. Health plans conduct PIPs to examine and improve areas of service or care identified by HHSC in consultation with Texas's EQRO as needing improvement. Topics are selected based on health plan performance on quality measures and member surveys. HHSC requires each health plan to conduct two PIPs per program. One PIP per health plan

must be a collaborative with another health plan or a DSRIP project, or a community-based organization.

**Performance Indicator Dashboards:** Texas's EQRO began producing Performance Indicator Dashboards in 2018. The dashboards include a series of measures that identify key aspects of MCO performance by MMC program to support transparency and accountability. MCOs whose performance falls below minimum standard thresholds for 33.33 percent or more of measures on the Performance Indicator Dashboard will be subject to remedies under the contract, including placement on a corrective action plan.

## **Appendix D. DPP Descriptions**

The DPP evaluation component includes five DPPs. The first—QIPP—was designed to drive transformation in the quality of nursing facility services. The four additional DPPs—CHIRP, DPP BHS, RAPPS, and TIPPS—were designed to sustain key DSRIP initiatives and support further delivery system reform by incentivizing providers to improve access and quality of care.

CHIRP is designed to incentivize hospitals to improve access, quality, and innovation in the provision of hospital services to Medicaid recipients. CHIRP includes two components.

- Component 1 replaces UHRIP, which has been in operation since December 1, 2017. Under UHRIP, HHSC directs MCOs to provide a uniform percentage rate increase to hospitals in the MCO's network in a designated service area for the provision of inpatient services, outpatient services, or both. CHIRP will continue to offer UHRIP-like uniform rate increases to hospitals through MCOs.
- Component 2 is a new program, called the Average Commercial Incentive Award (ACIA), that allows participating providers to earn higher reimbursement rates based on a percentage of the estimated commercial reimbursement. ACIA includes six modules: maternal care, hospital safety, pediatric hospital safety, psychiatric care transitions, care transitions, and rural hospital best practices. ACIA payments will be paid as a uniform rate increase per class and will be distributed based on actual paid claims. Similar to Component 1, HHSC funds are provided to the MCOs to distribute among enrolled hospitals.

DPP BHS is designed to incentivize CMHCs to improve quality, access, and innovation in the provision of medical and behavioral health services to Medicaid recipients. DPP BHS includes two components.

- Component 1, which accounts for 65 percent of available funding, will provide a uniform dollar increase in the form of prospective monthly payments to CMHCs for maintaining or working toward Certified Community Behavioral Health Clinic (CCBHC) certification.
- Component 2, allows providers an opportunity to earn an enhanced rate on CCBHC services triggered by the reporting or achievement of the required process and outcome measures.

RAPPS is designed to incentivize Rural Health Clinics (RHCs) to improve quality, access, and innovation in the provision of medical services to Medicaid recipients. RAPPS includes two components.

- Component 1 will provide a uniform dollar increase in the form of prospective, monthly payments to all participating RHCs.



- Component 2, which would account for 25 percent of available funding for the program, allows providers an opportunity to earn a rate enhancement on the most common encounters based on achievement of quality measures focused on preventive care and management of chronic conditions.

TIPPS is designed to incentivize physicians and certain medical professionals to improve quality, access, and innovation in the provision of medical services to Medicaid recipients. TIPPS includes three components.

- Component 1 will be paid as a per member per month (PMPM) payment triggered by implementation of quality improvement activities.
- Component 2 serves as a performance incentive payment based on the achievement of quality measures focused on primary care and chronic care.
- Component 3 serves as a rate enhancement for certain outpatient services based on achievement of quality measures focused on maternal health, chronic care, behavioral health, and social determinants of health.

QIPP serves as a performance-based initiative to help nursing facilities achieve transformation in the quality of their services through implementation of innovative program-wide improvement processes. Nursing facilities participating in QIPP are compensated for meeting or exceeding certain goals, with improvement based on several indices of success, including quality measures collected by CMS. QIPP includes four components and funds are paid through the STAR+PLUS MMC PMPM capitation rates:

- Component 1 is open only to non-state-owned providers and serves as a universal rate increase payment. Facilities receive monthly payments if they (1) hold a QAPI Meeting each month, and (2) submit their QAPI Validation Report form and data demonstrating a nursing-facility-specific performance improvement project based on a Long-Stay MDS of relevance to the nursing facility.
- Component 2 serves as a performance incentive payment based on achievement of quality measures focused on workforce development. It is open to all provider types, and funds are distributed monthly.
- Component 3 serves as a performance incentive payment wherein all provider types are eligible to earn quarterly payments upon meeting program-wide and facility-specific targets on Long-Stay MDS quality measures.
- Component 4 is open only to non-state-owned providers as a performance incentive payment. Funds are distributed quarterly upon demonstrating evidence of an active infection control program that includes pursuing improved outcomes in vaccination rates and antibiotic stewardship. Facilities must meet staged performance targets over the four quarters of the program year.

## Appendix E. Detailed Tables

### MMC Component

**Evaluation Question 1: Did the expansion of the MMC service delivery model to additional populations or services improve health care outcomes for MMC clients?**

#### H1.1. Utilization of DRTS will increase for MMC members.

Measure 1.1.1	MMC members utilizing DRTS per month/quarter
<b>Definition</b>	The unique count of MMC members with a paid DRTS trip.
<b>Study Population</b>	MMC members utilizing DRTS
<b>Measure Steward or Source</b>	N/A
<b>Technical Specifications</b>	<p>Unique PCN count of MMC members with a paid FFS claim or MMC encounter for any DRTS trip.</p> <p>The unique PCN count can be calculated per month or quarter.</p>
<b>Exclusion Criteria</b>	If calculated quarterly: MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during quarter
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• FFS claims and MMC encounter data</li> <li>• Member-level enrollment files</li> <li>• Provider-level enrollment data</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:</p> <ul style="list-style-type: none"> <li>• Pre: 9/1/2017 - 5/31/2021</li> <li>• Post: 6/1/2021 - 5/31/2026</li> </ul> <p>Member characteristics (age, race/ethnicity, MMC program, region, etc.), where applicable</p> <p>Provider characteristics (DRTS provider type, etc.), where applicable</p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• ITS</li> </ul>
<b>Interpretation</b>	This measure is a direct indicator of utilization of DRTS for MMC members.
<b>Benchmark</b>	None

*Notes.* MMC=Medicaid managed care; DRTS=Demand response transportation services; PCN=Patient Control Number; FFS=Fee-for-service; ITS=Interrupted time series.

<b>Measure 1.1.2</b>	<b>DRTS trips per month/quarter</b>
<b>Definition</b>	The total number of DRTS trips provided.
<b>Study Population</b>	MMC members utilizing DRTS
<b>Measure Steward or Source</b>	N/A
<b>Technical Specifications</b>	Count of unique DRTS trips from paid FFS claims or MMC encounters. MMC members may have multiple paid DRTS trips in a single day (e.g., round trips or multiple stops). Each paid DRTS trip should be counted separately.  The count of DRTS trips can be calculated per month or quarter.
<b>Exclusion Criteria</b>	If calculated quarterly: MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during quarter
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• FFS claims and MMC encounter data</li> <li>• Member-level enrollment files</li> <li>• Provider-level enrollment data</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	Pre-post comparison: <ul style="list-style-type: none"> <li>• Pre: 9/1/2017 - 5/31/2021</li> <li>• Post: 6/1/2021 - 5/31/2026</li> </ul> Member characteristics (age, race/ethnicity, MMC program, region, etc.), where applicable Provider characteristics (DRTS provider type, etc.), where applicable
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• ITS</li> </ul>
<b>Interpretation</b>	This measure is a direct indicator of utilization of DRTS for MMC members.
<b>Benchmark</b>	None

*Notes.* DRTS=Demand response transportation services; MMC=Medicaid managed care; FFS=Fee-for-service; ITS=Interrupted time series.

<b>Measure 1.1.3</b>	<b>Average DRTS trips per month/quarter</b>
<b>Definition</b>	The average number of DRTS trips provided.
<b>Study Population</b>	MMC members utilizing DRTS
<b>Measure Steward or Source</b>	N/A
<b>Technical Specifications</b>	<p><b>Numerator:</b> Count of unique DRTS trips from paid FFS claims or MMC encounters</p> <p><b>Denominator:</b> Unique PCN count of MMC members with a paid FFS claim or MMC encounter for any DRTS trip</p> <p><b>Rate:</b> Numerator / Denominator</p> <p>The rate can be calculated per month or quarter. MMC members may have multiple paid DRTS trips in a single day (e.g., round trips or multiple stops). Each paid DRTS trip should be counted separately.</p>
<b>Exclusion Criteria</b>	If calculated quarterly: MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during quarter
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• FFS claims and MMC encounter data</li> <li>• Member-level enrollment files</li> <li>• Provider-level enrollment data</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:</p> <ul style="list-style-type: none"> <li>• Pre: 9/1/2017 - 5/31/2021</li> <li>• Post: 6/1/2021 - 5/31/2026</li> </ul> <p>Member characteristics (age, race/ethnicity, MMC program, region, etc.), where applicable</p> <p>Provider characteristics (DRTS provider type, etc.), where applicable</p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• ITS</li> </ul>
<b>Interpretation</b>	This measure is a direct indicator of utilization of DRTS for MMC members.
<b>Benchmark</b>	None

*Notes.* DRTS=Demand response transportation services; MMC=Medicaid managed care; FFS=Fee-for-service; PCN=Patient Control Number; ITS=Interrupted time series.

## H1.2. Access to health care services will improve for MMC members whose DRTS services were carved into MMC.

<b>Measure 1.2.1</b>	<b>Adults' access to preventive/ambulatory health services (HEDIS®-like)</b>
<b>Definition</b>	The percentage of adults who accessed preventive/ambulatory health care services.
<b>Study Population</b>	MMC members utilizing DRTS
<b>Measure Steward or Source</b>	NCQA (HEDIS®)-like measure: Adults' access to preventive/ambulatory health services (AAP)
<b>Technical Specifications</b>	<p><b>Numerator:</b> Number of MMC members utilizing DRTS who had an ambulatory or preventive care visit</p> <p><b>Denominator:</b> Number of MMC members utilizing DRTS</p> <p><b>Rate:</b> (Numerator / Denominator) * 100</p> <p>The rate can be calculated per quarter or DY.</p>
<b>Exclusion Criteria</b>	MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during quarter or DY
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• FFS claims and MMC encounter data</li> <li>• Member-level enrollment files</li> <li>• Provider-level enrollment data</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:</p> <ul style="list-style-type: none"> <li>• Pre: 9/1/2017 - 5/31/2021</li> <li>• Post: 6/1/2021 - 5/31/2026</li> </ul> <p>Member characteristics (age, race/ethnicity, MMC program, region, etc.), where applicable</p> <p>Provider characteristics (DRTS provider type, etc.), where applicable</p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> <li>• ITS, if feasible</li> </ul>
<b>Interpretation</b>	An increase in this measure following the transition of DRTS into MMC would suggest these services resulted in improvements in access to primary health care services for adult MMC members.
<b>Benchmark</b>	None

*Notes.* HEDIS®=Healthcare Effectiveness Data and Information Set; MMC=Medicaid managed care; DRTS=Demand response transportation services; NCQA=National Committee for Quality Assurance; DY=Demonstration year, October 1-September 30; FFS=Fee-for-service; DTA=Descriptive trend analysis; ITS=Interrupted time series.

<b>Measure 1.2.2</b>	<b>Child and adolescent well-care visits (HEDIS®)</b>
<b>Definition</b>	The percentage of MMC members utilizing DRTS who had at least one comprehensive well-care visit with a primary care practitioner or an obstetrician/gynecologist in DY.
<b>Study Population</b>	MMC members utilizing DRTS
<b>Measure Steward or Source</b>	<p>NCQA (HEDIS®): Child and adolescent well-care visits (W15, W34, AWC)</p> <p>The codes used to calculate this measure are publicly available on the Medicaid website:</p> <ul style="list-style-type: none"> <li>2021 Medicaid and CHIP Child Core Set: <a href="https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf">https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf</a></li> </ul> <p>The external evaluator should use the same HEDIS® technical specifications to calculate this measure across the entire study period.</p>
<b>Technical Specifications</b>	<p><b>Numerator:</b> Total number of unduplicated MMC members meeting denominator criteria with one or more well-care visits (as specified in CMS Well-Care Value Set) in DY</p> <p><b>Denominator:</b> Total number of unduplicated MMC members utilizing DRTS who were ages 3 to 21 at end of DY</p> <p><b>Rate:</b> (Numerator / Denominator) * 100</p>
<b>Exclusion Criteria</b>	MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during DY
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>FFS claims and MMC encounter data</li> <li>Member-level enrollment files</li> <li>Provider-level enrollment data</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:</p> <ul style="list-style-type: none"> <li>Pre: 9/1/2017 - 5/31/2021</li> <li>Post: 6/1/2021 - 5/31/2026</li> </ul> <p>Member characteristics (age, race/ethnicity, MMC program, region, etc.), where applicable</p> <p>Provider characteristics (DRTS provider type, etc.), where applicable</p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> </ul>
<b>Interpretation</b>	An increase in this measure following the transition of DRTS into MMC would suggest these services resulted in improvements in access to primary health care services for children and young adult MMC members.

Measure 1.2.2	Child and adolescent well-care visits (HEDIS®)
<b>Benchmark</b>	<p>Texas CMS Core Measure, 2019 Medicaid State Rate:<sup>1</sup></p> <ul style="list-style-type: none"> <li>W15: 66.1</li> <li>W34: 79.8</li> <li>AWC: 70.1</li> </ul> <p>NCQA Quality Compass 2020, 50th Percentile Benchmark:</p> <ul style="list-style-type: none"> <li>W15: 67.9</li> <li>W34: 74.7</li> <li>AWC: 57.2</li> </ul>

*Notes.* <sup>1</sup> Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: <https://thlcportal.com/measures/cmscoremeasuredashboard>.  
HEDIS®=Healthcare Effectiveness Data and Information Set; MMC=Medicaid managed care; DRTS=Demand response transportation services; DY=Demonstration year, October 1-September 30; NCQA=National Committee for Quality Assurance; CHIP=Children's Health Insurance Program; CMS=Centers for Medicare and Medicaid Services; FFS=Fee-for-service; DTA=Descriptive trend analysis.

Measure 1.2.3	Utilization of pharmacy benefits
<b>Definition</b>	MMC members utilizing DRTS who received pharmacy benefits.
<b>Study Population</b>	MMC members utilizing DRTS
<b>Measure Steward or Source</b>	N/A
<b>Technical Specifications</b>	<p>Utilization of pharmacy benefits is calculated using two rates: 1) MMC members utilizing pharmacy benefits, and 2) Medications filled.</p> <p><b>Numerator 1:</b> Unique PCN count of MMC members meeting denominator criteria with a paid pharmacy claim  <b>Denominator 1:</b> Unique PCN count of MMC members with a paid FFS claim or MMC encounter for DRTS  <b>Rate 1:</b> (Numerator / Denominator) * 100</p> <p><b>Numerator 2:</b> Count of paid medications filled for MMC members meeting denominator criteria  <b>Denominator 2:</b> Unique PCN count of MMC members with a paid FFS claim or MMC encounter for DRTS  <b>Rate 2:</b> Numerator / Denominator</p> <p>Both rates can be calculated per month or quarter.</p>
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>FFS claims and MMC encounter data</li> <li>Member-level enrollment files</li> <li>Member-level pharmacy data</li> <li>Provider-level enrollment data</li> </ul>

<b>Measure 1.2.3</b>	<b>Utilization of pharmacy benefits</b>
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:</p> <ul style="list-style-type: none"> <li>• Pre: 9/1/2017 - 5/31/2021</li> <li>• Post: 6/1/2021 - 5/31/2026</li> </ul> <p>Member characteristics (age, race/ethnicity, MMC program, region, etc.), where applicable</p> <p>Provider characteristics (DRTS provider type, etc.), where applicable</p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• ITS</li> </ul>
<b>Interpretation</b>	An increase in this measure following the transition of DRTS into MMC would suggest these services resulted in improvements in access to pharmacy-related health care services for MMC members.
<b>Benchmark</b>	None

*Notes.* MMC=Medicaid managed care; DRTS=Demand response transportation services; FFS=Fee-for-service; PCN=Patient Control Number; FFS=Fee-for-service; ITS=Interrupted time series.

### **H1.3 Preventable emergency department use will decrease among Medicaid members whose DRTS services were carved into MMC.**

<b>Measure 1.3.1</b>	<b>Prevention quality overall composite (PQI #90)</b>
<b>Definition</b>	Overall composite measure of hospital admissions for acute conditions per 100,000 adult population.
<b>Study Population</b>	MMC members utilizing DRTS
<b>Measure Steward or Source</b>	<p>AHRQ</p> <p>The codes used to calculate this measure are publicly available on the AHRQ website. At the time of writing, July 2020 PQI Technical Specifications were available at:</p> <ul style="list-style-type: none"> <li>• Prevention Quality Indicators Technical Specifications, Version v2020:  <a href="https://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec_ICD10_v2020.aspx">https://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec_ICD10_v2020.aspx</a> </li> </ul> <p>The external evaluator should use the same PQI technical specifications to calculate this measure across the entire study period.</p>



Measure 1.3.1	Prevention quality overall composite (PQI #90)
<b>Technical Specifications</b>	<p>The measure includes admissions with a principal diagnosis of one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary, disease, asthma, hypertension, heart failure, angina without a cardiac procedure, dehydration, bacterial pneumonia, or urinary tract infection.</p> <p><b>Numerator:</b> Number of hospital discharges for MMC members utilizing DRTS, ages 18 or order, that meet the inclusion and exclusion rules for the numerator in any of the PQIs included in the overall composite measure (PQI #s 1, 3, 5, 7, 8, 10, 11, 12, 13, 14, 15, and 16)<sup>1</sup></p> <p><b>Denominator:</b> MMC members utilizing DRTS, ages 18 or order</p> <p><b>Rate:</b> (Numerator / Denominator) * 100</p> <p>The rate can be calculated per quarter or DY. However, quarterly rates should be interpreted with caution given seasonal differences for many conditions.</p>
<b>Exclusion Criteria</b>	<p>MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during quarter or DY</p> <p>Numerator exclusion criteria defined for each PQI</p>
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• FFS claims and MMC encounter data</li> <li>• Member-level enrollment files</li> <li>• Provider-level enrollment data</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:</p> <ul style="list-style-type: none"> <li>• Pre: 9/1/2017 - 5/31/2021</li> <li>• Post: 6/1/2021 - 5/31/2026</li> </ul> <p>Member characteristics (age, race/ethnicity, MMC program, region, etc.), where applicable</p> <p>Provider characteristics (DRTS provider type, etc.), where applicable</p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> <li>• ITS, if feasible</li> </ul>
<b>Interpretation</b>	<p>A decrease in this measure following the transition of DRTS into MMC would suggest these services reduce avoidable hospital admissions for adult MMC members.</p>

<b>Measure 1.3.1</b>	<b>Prevention quality overall composite (PQI #90)</b>
<b>Benchmark</b>	None

*Notes.* <sup>1</sup> MMC members who meet the inclusion and exclusion criteria rules for the numerator in more than one PQI are only counted once in the overall composite measure. PQI=Prevention quality indicators; MMC=Medicaid managed care; DRTS=Demand response transportation services; AHRQ=Agency for Healthcare Research and Quality; DY=Demonstration year, October 1-September 30; FFS=Fee-for-service; DTA=Descriptive trend analysis; ITS=Interrupted time series.

<b>Measure 1.3.2</b>	<b>Pediatric quality overall composite (PDI #90)</b>
<b>Definition</b>	Overall composite measure of hospital admissions for acute conditions per 100,000 child population.
<b>Study Population</b>	MMC members utilizing DRTS
<b>Measure Steward or Source</b>	<p>AHRQ</p> <p>The codes used to calculate this measure are publicly available on the AHRQ website. At the time of writing, July 2020 PDI Technical Specifications were available at:</p> <ul style="list-style-type: none"> <li>Pediatric Quality Indicators Technical Specifications, Version v2020: <a href="https://www.qualityindicators.ahrq.gov/Modules/PDI_TechSpec_ICD10_v2020.aspx">https://www.qualityindicators.ahrq.gov/Modules/PDI_TechSpec_ICD10_v2020.aspx</a></li> </ul> <p>The external evaluator should use the same PDI technical specifications to calculate this measure across the entire study period.</p>
<b>Technical Specifications</b>	<p>The measure includes admissions with a principal diagnosis of one of the following conditions: asthma, diabetes with short-term complications, gastroenteritis, or urinary tract infection.</p> <p><b>Numerator:</b> Number of hospital discharges for MMC members utilizing DRTS, ages 6 to 17, that meet the inclusion and exclusion rules for the numerator in any of the PDIs included in the overall composite measure (PDI #s 14, 15, 16, and 18)<sup>1</sup></p> <p><b>Denominator:</b> MMC members utilizing DRTS, ages 6 to 17</p> <p><b>Rate:</b> (Numerator / Denominator) * 100</p> <p>The rate can be calculated per quarter or DY. However, quarterly rates should be interpreted with caution given seasonal differences for many conditions.</p>
<b>Exclusion Criteria</b>	<p>MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during quarter or DY</p> <p>Numerator exclusion criteria defined for each PDI</p>

<b>Measure 1.3.2</b>	<b>Pediatric quality overall composite (PDI #90)</b>
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• FFS claims and MMC encounter data</li> <li>• Member-level enrollment files</li> <li>• Provider-level enrollment data</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:</p> <ul style="list-style-type: none"> <li>• Pre: 9/1/2017 - 5/31/2021</li> <li>• Post: 6/1/2021 - 5/31/2026</li> </ul> <p>Member characteristics (age, race/ethnicity, MMC program, region, etc.), where applicable</p> <p>Provider characteristics (DRTS provider type, etc.), where applicable</p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> <li>• ITS, if feasible</li> </ul>
<b>Interpretation</b>	A decrease in this measure following the transition of DRTS into MMC would suggest these services reduce hospital admissions for child MMC members.
<b>Benchmark</b>	None

*Notes.* <sup>1</sup> MMC members who meet the inclusion and exclusion criteria rules for the numerator in more than one PDI are only counted once in the overall composite measure. PDI=Pediatric quality indicators; MMC=Medicaid managed care; DRTS=Demand response transportation services; AHRQ=Agency for Healthcare Research and Quality; DY=Demonstration year, October 1-September 30; FFS=Fee-for-service; DTA=Descriptive trend analysis; ITS=Interrupted time series.

## **Evaluation Question 2: Did the MMC service delivery model improve access to and quality of care over time?**

### **H2.1. Access to preventive care will maintain or improve over time.**

<b>Measure 2.1.1</b>	<b>Childhood immunization status (HEDIS®)</b>
<b>Definition</b>	<p>The percentage of children age 2 who received the following vaccines by their 2<sup>nd</sup> birthday:</p> <ul style="list-style-type: none"> <li>• Four diphtheria, tetanus and acellular pertussis (DTaP);</li> <li>• Three polio (IPV);</li> <li>• One measles, mumps and rubella (MMR);</li> <li>• Three haemophilus influenza type B (HiB);</li> <li>• Three hepatitis B (HepB);</li> <li>• One chicken pox (VZV);</li> <li>• Four pneumococcal conjugate (PCV);</li> <li>• One hepatitis A (HepA);</li> <li>• Two or three rotavirus (RV); and</li> <li>• Two influenza</li> </ul>
<b>Study Population</b>	STAR; STAR+PLUS; STAR Kids

<b>Measure 2.1.1</b>	<b>Childhood immunization status (HEDIS®)</b>
<b>Measure Steward or Source</b>	EQRO-calculated NCQA (HEDIS®) measure: Childhood immunization status (CIS)
<b>Technical Specifications</b>	<p>As of CY 2019, the EQRO calculated a rate for each of the 10 vaccines, as well as three combination rates:</p> <ul style="list-style-type: none"> <li>• Combination 2: DTaP, IPV, HiB, HebP, and VZV</li> <li>• Combination 4: DTaP, IVP, MMR, HiB, HepB, VZV, PCV, HepA</li> <li>• Combination 10: DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV, and influenza</li> </ul> <p>For each rate:  <b>Numerator:</b> Children meeting the denominator criteria with evidence that vaccine requirement was met  <b>Denominator:</b> Children who turn age 2 during CY, who were enrolled in MMC for 12 months prior to 2<sup>nd</sup> birthday  <b>Rate:</b> (Numerator / Denominator) * 100</p>
<b>Exclusion Criteria</b>	MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during CY
<b>Data Source(s)/Data Collection Methods</b>	EQRO-calculated MMC performance measures
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:</p> <ul style="list-style-type: none"> <li>• STAR Pre: 9/1/2006 - 12/31/2011<sup>1</sup></li> <li>• STAR Post: 1/1/2012 - 12/31/2029<sup>2</sup></li> <li>• STAR+PLUS Pre: 9/1/2006 - 12/31/2011</li> <li>• STAR+PLUS Post: 1/1/2012 - 12/31/2029</li> <li>• STAR Kids Post Only: 1/1/2017 - 12/31/2029</li> </ul> <p>Member characteristics (gender, race/ethnicity, region, etc.), where applicable<sup>3</sup></p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	Increases in the rates under this measure over time would suggest MMC members experienced improvements in access to preventive care for children.
<b>Benchmark</b>	<p>Texas CMS Core Measure, 2019 Medicaid State Rate:<sup>4</sup></p> <ul style="list-style-type: none"> <li>• Combination 2: 72.4</li> <li>• Combination 4: 69.7</li> <li>• Combination 10: 32.0</li> </ul> <p>NCQA Quality Compass 2020, 50<sup>th</sup> Percentile Benchmark:</p> <ul style="list-style-type: none"> <li>• Combination 2: 74.1</li> <li>• Combination 4: 69.0</li> <li>• Combination 10: 37.5</li> </ul>

*Notes.* <sup>1</sup> Prior to January 1, 2010, the EQRO calculated Texas MMC program measures each State Fiscal Year (September 1 – August 31). Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods for Texas MMC program measures do not align with DYs. <sup>2</sup> The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative evaluation report. <sup>3</sup> Member subgroups may not be available for all years. <sup>4</sup> Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: <https://thlcportal.com/measures/cmscoremeasuredashboard>. HEDIS®=Healthcare Effectiveness Data and Information Set; DTaP=Diphtheria, tetanus and acellular pertussis; IPV=Inactivated polio vaccine; MMR=Measles, mumps, and rubella; HiB=Haemophilus influenza type B; HepB=Hepatitis B; VZV=Varicella-zoster virus; PCV=Pneumococcal conjugate virus; HepA=Hepatitis A; RV=Rotavirus; STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; STAR Kids=MMC program serving disabled individuals 20 years or younger; EQRO=Texas's External Quality Review Organization; NCQA=National Committee for Quality Assurance; CY=Calendar year, January 1-December 31; MMC=Medicaid managed care; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30.

<b>Measure 2.1.2</b>	<b>Immunization for adolescents (HEDIS®)</b>
<b>Definition</b>	The percentage of adolescents age 13 who received the following vaccines by their 13 <sup>th</sup> birthday: <ul style="list-style-type: none"> <li>• One meningococcal conjugate (MCV4)</li> <li>• One tetanus, diphtheria toxoids and acellular pertussis (Tdap)</li> <li>• Three human papillomavirus (HPV)</li> </ul>
<b>Study Population</b>	STAR; STAR Kids
<b>Measure Steward or Source</b>	EQRO-calculated NCQA (HEDIS®) measure: Immunization for adolescents (IMA)
<b>Technical Specifications</b>	As of CY 2019, the EQRO calculated a rate for each of the 3 vaccines, as well as two combination rates: <ul style="list-style-type: none"> <li>• Combination 1: MCV4, Tdap</li> <li>• Combination 2: MCV4, Tdap, HPV</li> </ul> For each rate: <b>Numerator:</b> Adolescents meeting the denominator criteria with evidence that vaccine requirement was met <b>Denominator:</b> Adolescents who turn age 13 during CY, who were enrolled in MMC for 12 months prior to 13 <sup>th</sup> birthday <b>Rate:</b> (Numerator / Denominator) * 100
<b>Exclusion Criteria</b>	MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during CY
<b>Data Source(s)/Data Collection Methods</b>	EQRO-calculated MMC performance measures

<b>Measure 2.1.2</b>	<b>Immunization for adolescents (HEDIS®)</b>
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:</p> <ul style="list-style-type: none"> <li>• STAR Pre: 9/1/2009 - 12/31/2011<sup>1</sup></li> <li>• STAR Post: 1/1/2012 - 12/31/2029<sup>2</sup></li> <li>• STAR Kids Post Only: 1/1/2017 - 12/31/2029</li> </ul> <p>Member characteristics (gender, race/ethnicity, region, etc.), where applicable<sup>3</sup></p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	Increases in the rates under this measure over time would suggest MMC members experienced improvements in access to preventive care for adolescents.
<b>Benchmark</b>	<p>Texas CMS Core Measure, 2019 Medicaid State Rate:<sup>4</sup></p> <ul style="list-style-type: none"> <li>• Combination 1: 85.6</li> <li>• Combination 2: 40.3</li> </ul> <p>NCQA Quality Compass 2020, 50<sup>th</sup> Percentile Benchmark:</p> <ul style="list-style-type: none"> <li>• Combination 1: 82.3</li> <li>• Combination 2: 36.7</li> </ul>

*Notes.* <sup>1</sup> Prior to January 1, 2010, the EQRO calculated Texas MMC program measures each State Fiscal Year (September 1 – August 31). Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods for Texas MMC program measures do not align with DYs. <sup>2</sup> The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative evaluation report. <sup>3</sup> Member subgroups may not be available for all years. <sup>4</sup> Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: <https://thlcportal.com/measures/cmscoremeasuredashboard>. HEDIS®=Healthcare Effectiveness Data and Information Set; MCV4=Meningococcal conjugate vaccines; Tdap=Tetanus, diphtheria toxoids and acellular pertussis; HPV=Human papillomavirus; STAR=MMC program primarily serving children and pregnant women; STAR Kids=MMC program serving disabled individuals 20 years or younger; EQRO=Texas's External Quality Review Organization; NCQA=National Committee for Quality Assurance; CY=Calendar year, January 1-December 31; MMC=Medicaid managed care; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; DY=Demonstration year, October 1-September 30.

<b>Measure 2.1.3</b>	<b>Prenatal and postpartum care (HEDIS®)</b>
<b>Definition</b>	The percentage of women who received appropriate prenatal and postpartum care.
<b>Study Population</b>	STAR; STAR+PLUS; STAR Kids
<b>Measure Steward or Source</b>	EQRO-calculated NCQA (HEDIS®) measure: Prenatal and postpartum care (PPC)
<b>Technical Specifications</b>	<p>The HEDIS® measure includes two rates: 1) Timeliness of prenatal care and 2) Postpartum care.</p> <p><b>Numerator 1:</b> Women meeting the denominator criteria who received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the MMC</p> <p><b>Denominator 1:</b> Women who delivered a live birth between October 8 of prior CY and October 7 of current CY, who were enrolled in MMC 43 days prior to delivery through 60 days after delivery</p> <p><b>Rate 1:</b> (Numerator 1 / Denominator 1) * 100</p> <p><b>Numerator 2:</b> Women meeting the denominator criteria who received a postpartum visit between 7 and 84 days after delivery</p> <p><b>Denominator 2:</b> Women who delivered a live birth between October 8 of prior CY and October 7 of current CY, who were enrolled in MMC 43 days prior to delivery through 60 days after delivery</p> <p><b>Rate 2:</b> (Numerator 2 / Denominator 2) * 100</p>
<b>Exclusion Criteria</b>	<p>Non-live births</p> <p>MMC members with any gaps in enrollment</p>
<b>Data Source(s)/Data Collection Methods</b>	EQRO-calculated MMC performance measures
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:</p> <ul style="list-style-type: none"> <li>STAR Pre: 9/1/2006 - 12/31/2011<sup>1</sup></li> <li>STAR Post: 1/1/2012 - 12/31/2029<sup>2</sup></li> <li>STAR+PLUS Pre: 9/1/2006 - 12/31/2011</li> <li>STAR+PLUS Post: 1/1/2012 - 12/31/2029</li> <li>STAR Kids Post Only: 1/1/2017 - 12/31/2029</li> </ul> <p>Member characteristics (race/ethnicity, region, etc.), where applicable<sup>3</sup></p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> </ul>
<b>Interpretation</b>	Increases in the rates under this measure over time would suggest MMC members experienced improvements in access to appropriate maternal care.



<b>Measure 2.1.3</b>	<b>Prenatal and postpartum care (HEDIS®)</b>
<b>Benchmark</b>	<p>Texas CMS Core Measure, 2019 Medicaid State Rate, Postpartum care: 78.1<sup>4</sup></p> <p>NCQA Quality Compass 2020, 50<sup>th</sup> Percentile Benchmark:</p> <ul style="list-style-type: none"> <li>• Timeliness of prenatal care: 89.1</li> <li>• Postpartum care: 2: 76.4</li> </ul>

*Notes.* <sup>1</sup> Prior to January 1, 2010, the EQRO calculated Texas MMC program measures each State Fiscal Year (September 1 – August 31). Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods for Texas MMC program measures do not align with DYs. <sup>2</sup> The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative evaluation report. <sup>3</sup> Member subgroups may not be available for all years. <sup>4</sup> Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: <https://thlcportal.com/measures/cmscoremeasuredashboard>. HEDIS®=Healthcare Effectiveness Data and Information Set; STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; STAR Kids=MMC program serving disabled individuals 20 years or younger; EQRO=Texas's External Quality Review Organization; NCQA=National Committee for Quality Assurance; MMC=Medicaid managed care; CY=Calendar year, January 1-December 31; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; DY=Demonstration year, October 1-September 30.

<b>Measure 2.1.4</b>	<b>Cervical cancer screening (HEDIS®)</b>
<b>Definition</b>	The percentage of women age 21 to 64 screened for cervical cancer in past 3 (cervical cytology) or 5 years (cervical cytology/human papillomavirus co-testing).
<b>Study Population</b>	STAR; STAR+PLUS
<b>Measure Steward or Source</b>	EQRO-calculated NCQA (HEDIS®) measure: Cervical cancer screening (CCS)
<b>Technical Specifications</b>	<p><b>Numerator 1:</b> Women meeting the denominator criteria who had cervical cytology during CY or in the previous two to CYs</p> <p><b>Numerator 2:</b> Among women who do not meet criteria in Numerator 1, women meeting the denominator criteria who had cervical cytology and a human papillomavirus test with service dates four or fewer days apart during CY or in the previous four CYs (and who were age 30 or older on date of both tests)</p> <p><b>Final Numerator:</b> Numerator 1 + Numerator 2</p> <p><b>Denominator:</b> Total number of women who are ages 24 to 64 as of December 31</p> <p><b>Rate:</b> (Final Numerator / Denominator) * 100</p>



<b>Measure 2.1.4</b>	<b>Cervical cancer screening (HEDIS®)</b>
<b>Exclusion Criteria</b>	<p>MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during CY</p> <p>MMC members receiving hospice care</p> <p>Optional: MMC members with hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix at any time in member's history through end of CY</p>
<b>Data Source(s)/Data Collection Methods</b>	EQRO-calculated MMC performance measures
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:</p> <ul style="list-style-type: none"> <li>• STAR Pre: 9/1/2006 - 12/31/2011<sup>1</sup></li> <li>• STAR Post: 1/1/2012 - 12/31/2029<sup>2</sup></li> <li>• STAR+PLUS Pre: 9/1/2006 - 12/31/2011</li> <li>• STAR+PLUS Post: 1/1/2012 - 12/31/2029</li> </ul> <p>Member characteristics (race/ethnicity, region, etc.), where applicable<sup>3</sup></p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	An increase in this measure over time would suggest MMC members experienced improvements in access to preventive cancer screenings.
<b>Benchmark</b>	<p>Texas CMS Core Measure, 2019 Medicaid State Rate: 53.4<sup>4</sup></p> <p>NCQA Quality Compass 2020, 50<sup>th</sup> Percentile Benchmark: 61.3</p>

*Notes.* <sup>1</sup> Prior to January 1, 2010, the EQRO calculated Texas MMC program measures each State Fiscal Year (September 1 – August 31). Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods for Texas MMC program measures do not align with DYs. <sup>2</sup> The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative evaluation report. <sup>3</sup> Member subgroups may not be available for all years. <sup>4</sup> Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: <https://thlcportal.com/measures/cmscoremeasuredashboard>. HEDIS®=Healthcare Effectiveness Data and Information Set; STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; EQRO=Texas's External Quality Review Organization; NCQA=National Committee for Quality Assurance; CY=Calendar year, January 1-December 31; MMC=Medicaid managed care; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; DY=Demonstration year, October 1-September 30.

<b>Measure 2.1.5</b>	<b>Breast cancer screening (HEDIS®)</b>
<b>Definition</b>	The percentage of women ages 50 to 74 who had a mammogram to screen for breast cancer.
<b>Study Population</b>	STAR; STAR+PLUS
<b>Measure Steward or Source</b>	EQRO-calculated NCQA (HEDIS®) measure: Breast cancer screening (BCS)
<b>Technical Specifications</b>	<p><b>Numerator:</b> Women meeting the denominator criteria with one or more mammograms any time on or before October 1 two years prior to the CYs and December 31 of CY</p> <p><b>Denominator:</b> All women ages 52 to 74 as of December 31 of CY (to account for the look-back period)</p> <p><b>Rate:</b> (Numerator / Denominator) * 100</p>
<b>Exclusion Criteria</b>	<p>MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during CY</p> <p>MMC members receiving hospice or palliative care, or MMC members with frailty and advanced illness</p> <p>Optional: MMC members with bilateral mastectomy, or unilateral mastectomy with bilateral modifier at any time in member's history through end of CY</p>
<b>Data Source(s)/Data Collection Methods</b>	EQRO-calculated MMC performance measures
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:</p> <ul style="list-style-type: none"> <li>• STAR Pre: 9/1/2006 - 12/31/2011<sup>1</sup></li> <li>• STAR Post: 1/1/2012 - 12/31/2029<sup>2</sup></li> <li>• STAR+PLUS Pre: 9/1/2006 - 12/31/2011</li> <li>• STAR+PLUS Post: 1/1/2012 - 12/31/2029</li> </ul> <p>Member characteristics (race/ethnicity, region, etc.), where applicable<sup>3</sup></p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	An increase in this measure over time would suggest MMC members experienced improvements in access to preventive cancer screenings.

<b>Measure 2.1.5</b>	<b>Breast cancer screening (HEDIS®)</b>
<b>Benchmark</b>	Texas CMS Core Measure, 2019 Medicaid State Rate: 50.4 <sup>4</sup>  NCQA Quality Compass 2020, 50 <sup>th</sup> Percentile Benchmark: 58.8

*Notes.* <sup>1</sup> Prior to January 1, 2010, the EQRO calculated Texas MMC program measures each State Fiscal Year (September 1 – August 31). Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods for Texas MMC program measures do not align with DYs. <sup>2</sup> The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative evaluation report. <sup>3</sup> Member subgroups may not be available for all years. <sup>4</sup> Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: <https://thlcportal.com/measures/cmscoremeasuredashboard>. HEDIS®=Healthcare Effectiveness Data and Information Set; STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; EQRO=Texas's External Quality Review Organization; NCQA=National Committee for Quality Assurance; CY=Calendar year, January 1-December 31; MMC=Medicaid managed care; CMS=Centers for Medicare and Medicaid Services; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; DY=Demonstration year, October 1-September 30.

## **H2.2. Effective treatment of chronic, complex, and serious conditions will maintain or improve over time.**

<b>Measure 2.2.1</b>	<b>Comprehensive diabetes care (HEDIS®)</b>
<b>Definition</b>	The percentage of MMC members ages 18 to 75 with type 1 or type 2 diabetes who had each of the following: <ul style="list-style-type: none"> <li>• HbA1c testing</li> <li>• HbA1c poor control (&gt;9.0%)</li> <li>• HbA1c control (&lt;8.0% or &lt;7.0% for select populations)</li> <li>• Eye exam (retinal) performed</li> <li>• Medical attention for nephropathy</li> <li>• BP control (&lt;140/90 mm Hg)</li> </ul>
<b>Study Population</b>	STAR; STAR+PLUS
<b>Measure Steward or Source</b>	EQRO-calculated NCQA (HEDIS®) measure: Comprehensive diabetes care (CDC)

Measure 2.2.1	Comprehensive diabetes care (HEDIS®)
<b>Technical Specifications</b>	<p>As of CY 2019, the EQRO calculated five rates under this measure:</p> <ul style="list-style-type: none"> <li>• HbA1c testing</li> <li>• HbA1c control (&lt;8.0%)</li> <li>• Eye exam (retinal) performed</li> <li>• Medical attention for nephropathy</li> <li>• BP control (&lt;140/90 mm Hg)</li> </ul> <p><b>Numerators:</b> MMC members meeting the denominator criteria specific to each rate:</p> <ul style="list-style-type: none"> <li>• <i>HbA1c testing:</i> Who had a HbA1c test performed in CY</li> <li>• <i>HbA1c control (&lt;8.0%):</i> Whose most recent HbA1c test result was &lt;8.0%</li> <li>• <i>Eye exam (retinal) performed:</i> Who had an eyes screening for diabetic retinal disease</li> <li>• <i>Medical attention for nephropathy:</i> With a screening for nephropathy or evidence of nephropathy in CY</li> <li>• <i>BP control (&lt;140/90 mm Hg):</i> Whose most recent blood pressure level was &lt;40/90mm Hg during CY</li> </ul> <p><b>Denominator (applicable to all rates):</b> MMC members ages 18 to 75 who with an inpatient discharge or two outpatient visits with a diagnosis of diabetes, or who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis in CY or previous CY</p> <p><b>Rate:</b> (Numerator / Denominator) * 100</p>
<b>Exclusion Criteria</b>	<p>MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during CY</p> <p>MMC members receiving hospice or palliative care, or MMC members with frailty and advanced illness</p> <p>MMC members aged 66 years of age or older as of December 31 of CY who were enrolled in an institutional special needs plan or living long-term in an institution at any point in CY</p>
<b>Data Source(s)/Data Collection Methods</b>	EQRO-calculated MMC performance measures
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:</p> <ul style="list-style-type: none"> <li>• STAR Pre: 9/1/2006 - 12/31/2011<sup>1</sup></li> <li>• STAR Post: 1/1/2012 - 12/31/2029<sup>2</sup></li> <li>• STAR+PLUS Pre: 9/1/2006 - 12/31/2011</li> <li>• STAR+PLUS Post: 1/1/2012 - 12/31/2029</li> </ul> <p>Member characteristics (gender, race/ethnicity, region, etc.), where applicable<sup>3</sup></p>

<b>Measure 2.2.1</b>	<b>Comprehensive diabetes care (HEDIS®)</b>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	Increases in the rates under this measure over time would suggest MMC members experienced improvements in the effective treatment of diabetes.
<b>Benchmark</b>	NCQA Quality Compass 2020, 50th Percentile Benchmark: <ul style="list-style-type: none"> <li>• HbA1c testing: 88.8</li> <li>• HbA1c control (&lt;8.0%): 51.8</li> <li>• Eye exam (retinal) performed: 58.6</li> <li>• Medical attention for nephropathy: 90.1</li> <li>• BP control (&lt;140/90 mm Hg): 64.0</li> </ul>

*Notes.* <sup>1</sup> Prior to January 1, 2010, the EQRO calculated Texas MMC program measures each State Fiscal Year (September 1 – August 31). Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods for Texas MMC program measures do not align with DYs. <sup>2</sup> The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative evaluation report. <sup>3</sup> Member subgroups may not be available for all years. HEDIS®=Healthcare Effectiveness Data and Information Set; MMC=Medicaid managed care; HbA1c=Hemoglobin A1c; BP=Blood pressure; STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; EQRO=Texas's External Quality Review Organization; NCQA=National Committee for Quality Assurance; CDC=Comprehensive Diabetes Care; CY=Calendar year, January 1-December 31; MMC=Medicaid managed care; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30.

<b>Measure 2.2.2</b>	<b>Controlling high blood pressure (HEDIS®)</b>
<b>Definition</b>	Percentage of beneficiaries ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mm Hg) during the measurement year.
<b>Study Population</b>	STAR; STAR+PLUS
<b>Measure Steward or Source</b>	EQRO-calculated NCQA (HEDIS®) measure: Controlling high blood pressure (CBP)
<b>Technical Specifications</b>	<p><b>Numerator:</b> MMC members meeting the denominator criteria whose most recent BP reading was taken on or after the date of the second diagnosis of hypertension where the BP reading was &lt; 140/90 mm Hg. If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP</p> <p><b>Denominator:</b> MMC members ages 18 to 85 as of December 31 of CY</p> <p><b>Rate:</b> (Numerator / Denominator) * 100</p>

<b>Measure 2.2.2</b>	<b>Controlling high blood pressure (HEDIS®)</b>
<b>Exclusion Criteria</b>	<p>MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) during CY</p> <p>Beneficiaries receiving palliative care</p> <p>Optional: MMC members with frailty and advanced illness, MMC members with evidence of end stage renal disease, dialysis or renal transplant before or during the CY, MMC members who are pregnant during CY, and MMC members with nonacute inpatient admission during CY</p>
<b>Data Source(s)/Data Collection Methods</b>	EQRO-calculated MMC performance measures
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:</p> <ul style="list-style-type: none"> <li>• STAR Pre: 9/1/2006 - 12/31/2011<sup>1</sup></li> <li>• STAR Post: 1/1/2012 - 12/31/2029<sup>2</sup></li> <li>• STAR+PLUS Pre: 9/1/2006 - 12/31/2011</li> <li>• STAR+PLUS Post: 1/1/2012 - 12/31/2029</li> </ul> <p>Member characteristics (gender, race/ethnicity, region, etc.), where applicable<sup>3</sup></p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	An increase in this measure over time would suggest MMC members experienced improvements in the effective treatment of high blood pressure.
<b>Benchmark</b>	<p>Texas CMS Core Measure, 2019 Medicaid State Rate: 49.6<sup>4</sup></p> <p>NCQA Quality Compass 2020, 50th Percentile Benchmark: 61.8</p>

*Notes.* <sup>1</sup> Prior to January 1, 2010, the EQRO calculated Texas MMC program measures each State Fiscal Year (September 1 – August 31). Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods for Texas MMC program measures do not align with DYs. <sup>2</sup> The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative evaluation report. <sup>3</sup> Member subgroups may not be available for all years. <sup>4</sup> Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: <https://thlcportal.com/measures/cmscoremeasuredashboard>. HEDIS®=Healthcare Effectiveness Data and Information Set; STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; EQRO=Texas's External Quality Review Organization; NCQA=National Committee for Quality Assurance; MMC=Medicaid Managed Care; BP=Blood pressure; CY=Calendar year, January 1-December 31; CMS=Centers for Medicare and Medicaid Services; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; DY=Demonstration year, October 1-September 30.

<b>Measure 2.2.3</b>	<b>Follow-up care for children prescribed ADHD medication (HEDIS®)</b>
<b>Definition</b>	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.
<b>Study Population</b>	STAR; STAR+PLUS; STAR Kids
<b>Measure Steward or Source</b>	EQRO-calculated NCQA (HEDIS®) measure: Follow-up care for children prescribed ADHD medication (ADD)
<b>Technical Specifications</b>	<p>The HEDIS® measure includes two rates: 1) Initiation phase and 2) Continuation and maintenance phase.</p> <p><b>Numerator 1:</b> Children meeting denominator criteria with a follow-up visit with a practitioner, within 30 days after the IPSD<sup>1</sup></p> <p><b>Numerator 2:</b> Among children who meet criteria in Numerator 1, children with at least two follow-up visits on different dates of service with any practitioner, from 31–300 days (9 months) after the IPSD. Only one of the two visits (during days 31–300) may be an e-visit or virtual check-in</p> <p><b>Denominator:</b> Children age 6 as of March 1 of the year prior to the CY to age 12 as of the last calendar day of February of the CY</p> <p><b>Rate 1 (Initiation phase):</b> (Numerator for Rate 1 / Denominator) * 100</p> <p><b>Rate 2 (Continuation and maintenance phase):</b> (Numerator for Rate 2 / Denominator) * 100</p>
<b>Exclusion Criteria</b>	<p>Children with narcolepsy</p> <p>MMC members receiving hospice care</p> <p>Rate 1 (Initiation phase): MMC members with gaps in MMC enrollment 120 days prior to IPSD through 300 days after IPSD</p> <p>Rate 2 (Continuation and maintenance phase): MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) 120 days prior to IPSD through 300 days after IPSD</p>
<b>Data Source(s)/Data Collection Methods</b>	EQRO-calculated MMC performance measures



<b>Measure 2.2.3</b>	<b>Follow-up care for children prescribed ADHD medication (HEDIS®)</b>
<b>Comparison Group(s)/ Subgroup(s)</b>	Pre-post comparison: <ul style="list-style-type: none"> <li>• STAR Pre: 9/1/2009- 12/31/2011<sup>2</sup></li> <li>• STAR Post: 1/1/2012 - 12/31/2029<sup>3</sup></li> <li>• STAR+PLUS Pre: 9/1/2009- 12/31/2011</li> <li>• STAR+PLUS Post: 1/1/2012 - 12/31/2029</li> <li>• STAR Kids Post Only: 1/1/2017 - 12/31/2029</li> </ul> Member characteristics (gender, race/ethnicity, region, etc.), where applicable <sup>4</sup>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	Increases in the rates under this measure over time would suggest MMC members experienced improvements in the effective management of ADHD.
<b>Benchmark</b>	Texas CMS Core Measure, 2019 Medicaid State Rate: <sup>5</sup> <ul style="list-style-type: none"> <li>• Initiation Phase: 41.7</li> <li>• Continuation and Maintenance Phase: 56.7</li> </ul> NCQA Quality Compass 2020, 50th Percentile Benchmark: <ul style="list-style-type: none"> <li>• Initiation Phase: 43.1</li> <li>• Continuation and Maintenance Phase: 54.8</li> </ul>

*Notes.* <sup>1</sup> The IPSD is the earliest prescription dispensing date for an ADHD medication where the date is in the Intake Period and there is a Negative Medication History. <sup>2</sup> Prior to January 1, 2010, the EQRO calculated Texas MMC program measures each State Fiscal Year (September 1 – August 31). Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods for Texas MMC program measures do not align with DYs. <sup>3</sup> The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative evaluation report. <sup>4</sup> Member subgroups may not be available for all years. <sup>5</sup> Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: <https://thlcportal.com/measures/cmscoremeasuredashboard>. HEDIS®=Healthcare Effectiveness Data and Information Set; ADHD=attention-deficit/hyperactivity disorder; STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; STAR Kids=MMC program serving disabled individuals 20 years or younger; EQRO=Texas's External Quality Review Organization; NCQA=National Committee for Quality Assurance; IPSD=Index Prescription Start Date; CY=Calendar year, January 1-December 31; MMC=Medicaid managed care; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; DY=Demonstration year, October 1-September 30.



<b>Measure 2.2.4</b>	<b>Antidepressant medication management (HEDIS®)</b>
<b>Definition</b>	The percentage of MMC members age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on antidepressant medication treatment.
<b>Study Population</b>	STAR; STAR+PLUS
<b>Measure Steward or Source</b>	EQRO-calculated NCQA (HEDIS®) measure: Antidepressant medication management (AMM)

Measure 2.2.4	Antidepressant medication management (HEDIS®)
<b>Technical Specifications</b>	<p>The HEDIS® measure includes two rates: 1) Effective acute phase treatment and 2) Effective continuation phase treatment.</p> <p><b>Numerator 1:</b> Total number of unduplicated MMC members age 18 and older with at least 84 days (12 weeks) of treatment with antidepressant medication beginning on the IPST<sup>1</sup> through 114 days after the IPST (115 total days). This allows gaps in medication treatment up to a total of 31 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication</p> <p><b>Numerator 2:</b> Total number of unduplicated MMC members age 18 and older with at least 180 days (6 months) of treatment with antidepressant medication beginning on the IPST through 231 days after the IPST (232 total days). This allows gaps in medication treatment up to a total of 52 days during the 232-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication</p> <p><b>Denominator:</b> Total number of unduplicated MMC members age 18 and older with any of the following:</p> <ul style="list-style-type: none"> <li>• An acute or nonacute inpatient stay with any diagnosis of major depression</li> <li>• An outpatient visit with any diagnosis of major depression</li> <li>• An intensive outpatient encounter or partial hospitalization with any diagnosis of major depression</li> <li>• A community mental health center visit with any diagnosis of major depression</li> <li>• Electroconvulsive therapy with any diagnosis of major depression</li> <li>• Transcranial magnetic stimulation visit with any diagnosis of major depression</li> <li>• A telehealth visit with any diagnosis of major depression</li> <li>• An observation visit with any diagnosis of major depression</li> <li>• An ED visit with any diagnosis of major depression</li> <li>• A telephone visit with any diagnosis of major depression</li> </ul> <p><b>Rate 1 (Effective acute phase treatment):</b> (Numerator 1 / Denominator) * 100</p> <p><b>Rate 2 (Effective continuation phase treatment):</b> (Numerator 2 / Denominator) * 100</p>

<b>Measure 2.2.4</b>	<b>Antidepressant medication management (HEDIS®)</b>
<b>Exclusion Criteria</b>	MMC members with one or more gaps in MMC enrollment lasting more than 45 days (or more than one month if enrollment determined monthly) 105 days prior to IPSD through 231 days after IPSD
<b>Data Source(s)/Data Collection Methods</b>	EQRO-calculated MMC performance measures
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:</p> <ul style="list-style-type: none"> <li>• STAR Pre: 9/1/2009 - 12/31/2011<sup>2</sup></li> <li>• STAR Post: 1/1/2012 - 12/31/2029<sup>3</sup></li> <li>• STAR+PLUS Pre: 9/1/2009 - 12/31/2011</li> <li>• STAR+PLUS Post: 1/1/2012 - 12/31/2029</li> </ul> <p>Member characteristics (gender, race/ethnicity, region, etc.), where applicable<sup>4</sup></p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	Increases in the rates under this measure over time would suggest MMC members experienced improvements in the effective treatment of mental health conditions.
<b>Benchmark</b>	<p>Texas CMS Core Measure, 2019 Medicaid State Rate:<sup>5</sup></p> <ul style="list-style-type: none"> <li>• Effective Acute Phase Treatment: 53.2</li> <li>• Effective Continuation Phase Treatment: 37.5</li> </ul> <p>NCQA Quality Compass 2020, 50th Percentile Benchmark:</p> <ul style="list-style-type: none"> <li>• Effective Acute Phase Treatment: 53.7</li> <li>• Effective Continuation Phase Treatment: 38.4</li> </ul>

*Notes.* <sup>1</sup> The IPSD is the earliest prescription dispensing event for an antidepressant medication during the period of 270 days prior to the start of the measurement period through 90 days after the start of the measurement period. <sup>2</sup> Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods do not align with DYs. <sup>2</sup> The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative evaluation report. <sup>3</sup> Member subgroups may not be available for all years. <sup>5</sup> Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: <https://thlcportal.com/measures/cmscoremeasuredashboard>. HEDIS®=Healthcare Effectiveness Data and Information Set; MMC=Medicaid Managed Care; STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; EQRO=Texas's External Quality Review Organization; NCQA=National Committee for Quality Assurance; IPSD=Index Prescription Start Date; ED=Emergency department; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; DY=Demonstration year, October 1-September 30.

<b>Measure 2.2.5</b>	<b>Follow-up after hospitalization for mental illness (HEDIS®)</b>
<b>Definition</b>	The percentage of discharges for MMC members, 6 years of age and older, who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit within 7- or 30-days of discharge.
<b>Study Population</b>	STAR; STAR+PLUS; STAR Kids
<b>Measure Steward or Source</b>	EQRO-calculated NCQA (HEDIS®) measure: Follow-up after hospitalization for mental illness (FUH)
<b>Technical Specifications</b>	<p><b>7-Day Numerator:</b> MMC member meeting the denominator criteria with a follow-up visit with a mental health provider within 7 days after acute inpatient discharge</p> <p><b>30-Day Numerator:</b> MMC member meeting the denominator criteria with a follow-up visit with a mental health provider within 30 days after acute inpatient discharge</p> <p><b>Denominator:</b> MMC members 6 years of age and older who were discharged from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness or intentional self-harm in measurement period</p> <p><b>7-Day Rate:</b> (7-day Numerator / Denominator) * 100</p> <p><b>30-Day Rate:</b> (30-day Numerator / Denominator) * 100</p>
<b>Exclusion Criteria</b>	<p>Discharges followed by readmission or direct transfer to a non-acute facility within the 7- or 30-day follow-up period, regardless of principal diagnosis for the readmission, or to an acute facility within the 7- or 30-day follow-up period if the principal diagnosis was for non-mental health</p> <p>Clinician-document reason MMC member was not able to complete 7- or 30-day follow-up from acute inpatient setting discharge (i.e., member death prior to follow-up visit, member non-compliance for follow-up)</p> <p>MMC members receiving hospice care</p> <p>Follow-up visits that occur on the date of discharge</p>
<b>Data Source(s)/Data Collection Methods</b>	EQRO-calculated MMC performance measures

<b>Measure 2.2.5</b>	<b>Follow-up after hospitalization for mental illness (HEDIS®)</b>
<b>Comparison Group(s)/ Subgroup(s)</b>	Pre-post comparison: <ul style="list-style-type: none"> <li>• STAR Pre: 9/1/2006- 12/31/2011<sup>1</sup></li> <li>• STAR Post: 1/1/2012 - 12/31/2029<sup>2</sup></li> <li>• STAR+PLUS Pre: 9/1/2006- 12/31/2011</li> <li>• STAR+PLUS Post: 1/1/2012 - 12/31/2029</li> </ul> Member characteristics (gender, race/ethnicity, region, etc.), where applicable <sup>3</sup>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	Increases in the rates under this measure over time would suggest MMC members experienced improvements in the effective treatment of mental health.
<b>Benchmark</b>	Texas CMS Core Measure, 2019 Medicaid State Rate: <sup>4</sup> <ul style="list-style-type: none"> <li>• 7-Day Age 6-17 Rate: 35.0</li> <li>• 7-Day Age 18+ Rate: 22.3</li> <li>• 30-Day Age 6-17 Rate: 58.5</li> <li>• 30-Day Age 18+ Rate: 40.9</li> </ul> NCQA Quality Compass 2020, 50 <sup>th</sup> Percentile Benchmark: <ul style="list-style-type: none"> <li>• 7-Day Rate: 36.8</li> <li>• 30-Day Rate: 59.4</li> </ul>

*Notes.* <sup>1</sup> Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods do not align with DYs. <sup>2</sup> The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative evaluation report. <sup>3</sup> Member subgroups may not be available for all years. <sup>4</sup> Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: <https://thlcportal.com/measures/cmscoremeasuredashboard>. HEDIS®=Healthcare Effectiveness Data and Information Set; MMC=Medicaid managed care; STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; STAR Kids=MMC program serving disabled individuals 20 years or younger; EQRO=Texas's External Quality Review Organization; NCQA=National Committee for Quality Assurance; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; DY=Demonstration year, October 1-September 30.

<b>Measure 2.2.6</b>	<b>Initiation and engagement of alcohol and other drug dependence treatment (HEDIS®)</b>
<b>Definition</b>	<p>The percentage of MMC members age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who:</p> <ul style="list-style-type: none"> <li>• Initiated treatment within 14 days of the diagnosis, and</li> <li>• Initiated treatment and were engaged in ongoing treatment within 34 days of the initiation visit.</li> </ul>
<b>Study Population</b>	STAR; STAR+PLUS
<b>Measure Steward or Source</b>	EQRO-calculated NCQA (HEDIS®) measure: Initiation and engagement of alcohol and other drug abuse or dependence treatment (IET)
<b>Technical Specifications</b>	<p>As of CY 2019, the EQRO calculated a rate for:</p> <ul style="list-style-type: none"> <li>• Alcohol abuse or dependence</li> <li>• Opioid abuse or dependence</li> <li>• Other drug abuse or dependence</li> <li>• Total alcohol/drug abuse or dependence</li> </ul> <p>For each rate:</p> <p><b>Initiation of AOD Treatment Numerator:</b> MMC member meeting the denominator criteria with initiation of AOD treatment within 14 days of the IESD<sup>1</sup></p> <p><b>Engagement of AOD Treatment Numerator:</b> MMC members meeting the denominator criteria with one or more AOD-related medications filled or at least two treatment engagement visits with an AOD-related diagnosis within 34 days of the initiation visit</p> <p><b>Denominator:</b> MMC members age 18 or older as of December 31 with a claim/encounter with an AOD-related diagnosis between January 1 and November 14 (IESD), and no claims/encounters with an AOD-related diagnosis for 60 days prior</p> <p><b>Initiation of AOD Treatment Rate:</b> (Initiation of AOD Treatment Numerator / Denominator) * 100</p> <p><b>Engagement of AOD Treatment Rate:</b> (Engagement of AOD Treatment Numerator / Denominator) * 100</p>
<b>Exclusion Criteria</b>	<p>MMC members not continuously enrolled for 60 days prior to IEDS through 47 days after IESD</p> <p>MMC members if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of CY</p> <p>MMC members receiving hospice care</p>
<b>Data Source(s)/Data Collection Methods</b>	EQRO-calculated MMC performance measures

<b>Measure 2.2.6</b>	<b>Initiation and engagement of alcohol and other drug dependence treatment (HEDIS®)</b>
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:</p> <ul style="list-style-type: none"> <li>• STAR Pre: 9/1/2009- 12/31/2011<sup>2</sup></li> <li>• STAR Post: 1/1/2012 - 12/31/2029<sup>3</sup></li> <li>• STAR+PLUS Pre: 9/1/2009 - 12/31/2011</li> </ul> <p>Member characteristics (gender, race/ethnicity, region, etc.), where applicable<sup>4</sup></p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	Increases in the rates under this measure over time would suggest MMC members experienced improvements in the effective treatment of substance use disorders.
<b>Benchmark</b>	<p>Texas CMS Core Measure, 2019 Medicaid State Rate:<sup>5</sup></p> <ul style="list-style-type: none"> <li>• Total Initiation of AOD Treatment: 40.0</li> <li>• Total Engagement of AOD Treatment: 7.8</li> </ul> <p>NCQA Quality Compass 2020, 50<sup>th</sup> Percentile Benchmark:</p> <ul style="list-style-type: none"> <li>• Total Initiation of AOD Treatment: 43.6</li> <li>• Total Engagement of AOD Treatment: 14.22</li> </ul>

*Notes.* <sup>1</sup> The IESD is the earliest date of service for an eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence. <sup>2</sup> Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods do not align with DYs. <sup>3</sup> The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative evaluation report. <sup>4</sup> Member subgroups may not be available for all years. <sup>5</sup> Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: <https://thlcportal.com/measures/cmsscoremeasuredashboard>. HEDIS®=Healthcare Effectiveness Data and Information Set; MMC=Medicaid managed care; AOD=Alcohol or other drug; STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; EQRO=Texas's External Quality Review Organization; NCQA=National Committee for Quality Assurance; CY=Calendar year, January 1-December 31; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; DY=Demonstration year, October 1-September 30.

## H2.3. Appropriate use of health care will maintain or improve over time.

<b>Measure 2.3.1</b>	<b>Potentially preventable admissions (3M)</b>
<b>Definition</b>	A hospital admission or long-term care facility stay that might have been reasonably prevented with adequate access to ambulatory care or health care coordination.
<b>Study Population</b>	STAR; STAR+PLUS; STAR Kids
<b>Measure Steward or Source</b>	EQRO-calculated measure using 3M software
<b>Technical Specifications</b>	<p>Following the 3M protocol, the EQRO identifies inpatient admissions at-risk for being a potentially preventable admission (PPA), actual PPAs, assigns weights, risk-adjusts PPAs, and calculates expected-to-actual PPA rates.</p> <p>As of CY 2019, the EQRO published the following information on PPAs:</p> <ul style="list-style-type: none"> <li>• Total at-risk admissions</li> <li>• The number of PPAs</li> <li>• Total weight of all PPAs</li> <li>• Expected weight across all PPAs</li> <li>• Actual weight divided by expected weight</li> <li>• Total member months</li> <li>• Total PPA weight per 1,000 members</li> <li>• Total PPA weight per 1,000 at-risk admissions</li> <li>• Sum of the institutional expenditures across all PPAs</li> </ul>
<b>Exclusion Criteria</b>	None besides exclusion criteria specified by 3M
<b>Data Source(s)/Data Collection Methods</b>	EQRO-calculated MMC performance measures
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:<sup>1</sup></p> <ul style="list-style-type: none"> <li>• STAR Post Only: 1/1/2012 - 12/31/2029<sup>2,3</sup></li> <li>• STAR+PLUS Post Only: 1/1/2012 - 12/31/2029<sup>3</sup></li> <li>• STAR Kids Post Only: 1/1/2017 - 12/31/2029<sup>3</sup></li> </ul> <p>Member characteristics (gender, age, race/ethnicity, region, etc.), where applicable<sup>4</sup></p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	A decrease in this measure over time would suggest MMC members experienced improvements in the appropriate use of ambulatory health care and care coordination.
<b>Benchmark</b>	None

Notes. <sup>1</sup> Due to 3M software changes, PPA rates prior to January 1, 2012 are excluded. <sup>2</sup> Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods do not align with DYs. <sup>3</sup> The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year



Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative Evaluation Report.<sup>4</sup> Member subgroups may not be available for all years. STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; STAR Kids=MMC program serving disabled individuals 20 years or younger; EQRO=Texas's External Quality Review Organization; PPA=Potentially preventable admission; CY=Calendar year, January 1-December 31; MMC=Medicaid managed care; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30.

<b>Measure 2.3.2</b>	<b>Potentially preventable emergency department visits (3M)</b>
<b>Definition</b>	Emergency treatment for a condition that could have been treated or prevented by a physician or other health care provider in a non-emergency setting.
<b>Study Population</b>	STAR; STAR+PLUS; STAR Kids
<b>Measure Steward or Source</b>	EQRO-calculated measure using 3M software
<b>Technical Specifications</b>	<p>Following the 3M protocol, the EQRO identifies ED visits at-risk for being a potentially preventable emergency department visit (PPV), actual PPVs, assigns weights, risk-adjusts PPVs, and calculates expected-to-actual PPV rates.</p> <p>As of CY 2019, the EQRO published the following information on PPVs:</p> <ul style="list-style-type: none"> <li>• Total at-risk ED visits</li> <li>• The number of PPVs</li> <li>• Total weight of all PPVs</li> <li>• Expected weight across all PPVs</li> <li>• Actual weight divided by expected weight</li> <li>• Total member months</li> <li>• Total PPV weight per 1,000 members</li> <li>• Total PPV weight per 1,000 at-risk admissions</li> <li>• Sum of the institutional expenditures across all PPVs</li> </ul>
<b>Exclusion Criteria</b>	None besides exclusion criteria specified by 3M
<b>Data Source(s)/Data Collection Methods</b>	EQRO-calculated MMC performance measures
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:<sup>1</sup></p> <ul style="list-style-type: none"> <li>• STAR Post Only: 1/1/2012 - 12/31/2029<sup>2,3</sup></li> <li>• STAR+PLUS Post Only: 1/1/2012 - 12/31/2029<sup>3</sup></li> <li>• STAR Kids Post Only: 1/1/2017 - 12/31/2029<sup>3</sup></li> </ul> <p>Member characteristics (gender, age, race/ethnicity, region, etc.), where applicable<sup>4</sup></p>

<b>Measure 2.3.2</b>	<b>Potentially preventable emergency department visits (3M)</b>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	A decrease in this measure over time would suggest MMC members experienced improvements in the appropriate use of non-emergency health care.
<b>Benchmark</b>	None

*Notes.* <sup>1</sup> Due to 3M software changes, PPV rates prior to January 1, 2012 are excluded. <sup>2</sup> Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods do not align with DYs. <sup>3</sup> The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative evaluation report. <sup>4</sup> Member subgroups may not be available for all years. STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; STAR Kids=MMC program serving disabled individuals 20 years or younger; EQRO=Texas's External Quality Review Organization; ED=Emergency department; PPV=Potentially preventable emergency department visit; CY=Calendar year, January 1-December 31; MMC=Medicaid managed care; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30.

## **H2.4. Poor care or care coordination which may result in unnecessary patient harm will maintain or reduce over time.**

<b>Measure 2.4.1</b>	<b>Potentially preventable complications (3M)</b>
<b>Definition</b>	A harmful event or negative outcome, such as an infection or surgical complication, that occurs during a hospital admission or a long-term care facility stay, which was not present on admission and might have resulted from poor care or treatment rather than from natural progression of the underlying disease.
<b>Study Population</b>	STAR; STAR+PLUS; STAR Kids
<b>Measure Steward or Source</b>	EQRO-calculated measure using 3M software

<b>Measure 2.4.1</b>	<b>Potentially preventable complications (3M)</b>
<b>Technical Specifications</b>	<p>Following the 3M protocol, the EQRO identifies inpatient admissions at-risk for being a PPC, actual PPCs, assigns weights, risk-adjusts PPCs, and calculates expected-to-actual PPC rates.</p> <p>As of CY 2019, the EQRO published the following information on PPCs:</p> <ul style="list-style-type: none"> <li>• Total at-risk admissions</li> <li>• Number of admissions that had one or more PPC</li> <li>• Number of PPCs</li> <li>• Total weight of all PPCs</li> <li>• Expected weight across all PPCs</li> <li>• Actual weight divided by expected weight</li> <li>• Total PPC weight per 1,000 at-risk admissions</li> </ul>
<b>Exclusion Criteria</b>	None besides exclusion criteria specified by 3M
<b>Data Source(s)/Data Collection Methods</b>	EQRO-calculated MMC performance measures
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:<sup>1</sup></p> <ul style="list-style-type: none"> <li>• STAR Post Only: 1/1/2016 - 12/31/2029<sup>2,3</sup></li> <li>• STAR+PLUS Post Only: 1/1/2016 - 12/31/2029<sup>3</sup></li> <li>• STAR Kids Post Only: 1/1/2017 - 12/31/2029<sup>3</sup></li> </ul> <p>Member characteristics (gender, age, race/ethnicity, region, etc.), where applicable<sup>4</sup></p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	A decrease in this measure over time would suggest MMC members experienced reductions in harmful patient outcomes resulting from poor care or care coordination.
<b>Benchmark</b>	None

*Notes.* <sup>1</sup> Due to 3M software changes, PPC rates prior to January 1, 2016 are excluded. <sup>2</sup> Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods do not align with DYs. <sup>3</sup> The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative evaluation report. <sup>4</sup> Member subgroups may not be available for all years. STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; STAR Kids=MMC program serving disabled individuals 20 years or younger; EQRO=Texas's External Quality Review Organization; PPC=Potentially preventable complication; CY=Calendar year, January 1-December 31; MMC=Medicaid managed care; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30.

<b>Measure 2.4.2</b>	<b>Potentially preventable readmissions (3M)</b>
<b>Definition</b>	A return hospitalization within 30 days that might have resulted from problems in care during a previous hospital stay or from deficiencies in a post-hospital discharge follow-up.
<b>Study Population</b>	STAR; STAR+PLUS; STAR Kids
<b>Measure Steward or Source</b>	EQRO-calculated measure using 3M software
<b>Technical Specifications</b>	<p>Following the 3M protocol, the EQRO identifies readmissions with a plausible clinical relationship to a prior admission, readmissions at-risk for being a PPR, actual PPRs, assigns weights, risk-adjusts PPRs, and calculates expected-to-actual PPR rates.</p> <p>As of CY 2019, the EQRO published the following information on PPRs:</p> <ul style="list-style-type: none"> <li>• Total at-risk admissions</li> <li>• The number of PPR chains</li> <li>• Number of PPRs</li> <li>• Total weight of all PPRs</li> <li>• Expected weight across all PPRs</li> <li>• Actual weight divided by expected weight</li> <li>• Total PPR weight per 1,000 at-risk admissions</li> <li>• Sum of the institutional expenditures across all PPRs</li> </ul>
<b>Exclusion Criteria</b>	None besides exclusion criteria specified by 3M
<b>Data Source(s)/Data Collection Methods</b>	EQRO-calculated MMC performance measures
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:<sup>1</sup></p> <ul style="list-style-type: none"> <li>• STAR Post Only: 1/1/2012 - 12/31/2029<sup>2,3</sup></li> <li>• STAR+PLUS Post Only: 1/1/2012 - 12/31/2029<sup>3</sup></li> <li>• STAR Kids Post Only: 1/1/2017 - 12/31/2029<sup>3</sup></li> </ul> <p>Member characteristics (gender, age, race/ethnicity, region, etc.), where applicable<sup>4</sup></p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	A decrease in this measure over time would suggest MMC members experienced reductions in unnecessary hospital readmissions resulting from poor care.
<b>Benchmark</b>	None

Notes. <sup>1</sup> Due to 3M software changes, PPR rates prior to January 1, 2012 are excluded. <sup>2</sup> Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods do not align with DYS. <sup>3</sup> The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The

external evaluator may extend the post-period if additional data become available prior to the Summative evaluation report. <sup>4</sup> Member subgroups may not be available for all years. STAR=MMC program primarily serving children and pregnant women; STAR+PLUS=MMC program serving aged and disabled clients; STAR Kids=MMC program serving disabled individuals 20 years or younger; EQRO=Texas's External Quality Review Organization; PPR=Potentially preventable readmission; CY=Calendar year, January 1-December 31; MMC=Medicaid managed care; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30.

## H2.5. MMC member experience will maintain or improve over time.

<b>Measure 2.5.1</b>	<b>Getting care quickly composite (CAHPS®)</b>
<b>Definition</b>	The percentage of members or caregivers who report "always" being able to get care quickly.
<b>Study Population</b>	STAR; STAR+PLUS; STAR Kids
<b>Measure Steward or Source</b>	AHRQ: Health Plan Survey 5.0H - Adult and Child Version (Medicaid) Including Medicaid and Children with Chronic Conditions Supplemental Items
<b>Technical Specifications</b>	<p><b>Members:</b> The percentage of member respondents who answered "Always" to the following questions:</p> <ul style="list-style-type: none"> <li>• In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?</li> <li>• In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?</li> </ul> <p><b>Caregiver:</b> Number of caregiver respondents who answered "Always" to the following questions:</p> <ul style="list-style-type: none"> <li>• In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed?</li> <li>• In the last 6 months, when you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed?</li> </ul> <p>Survey results are weighted to account for the probability of selection into the survey sample and potential response bias by members' race/ethnicity. The Getting Care Quickly composite score is the average percentage of member/caregiver respondents who answered "Always" across the two questions. The composite score is calculated using weighted counts.</p>
<b>Exclusion Criteria</b>	Members or caregivers who do not answer getting care quickly questions
<b>Data Source(s)/Data Collection Methods</b>	EQRO-calculated MMC performance measures

Measure 2.5.1	Getting care quickly composite (CAHPS®)
<b>Comparison Group(s)/ Subgroup(s)</b>	Pre-post comparison: <ul style="list-style-type: none"> <li>• STAR Post Only: 1/1/2012 - 12/31/2029<sup>1,2</sup></li> <li>• STAR+PLUS Pre: 9/1/2008 - 12/31/2011</li> <li>• STAR+PLUS Post: 1/1/2012 - 12/31/2029</li> <li>• STAR Kids Post Only: 1/1/2018 - 12/31/2029</li> </ul> Member characteristics (gender, race/ethnicity, region, etc.), where applicable <sup>3</sup>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	Increases in the rates under this measure over time would suggest MMC members experienced improvements in MMC members' experience getting care.
<b>Benchmark</b>	Texas CMS Core Measure, 2019 Medicaid State Rate: <sup>4</sup> <ul style="list-style-type: none"> <li>• Adult: 54.8</li> <li>• Child: 80.5</li> </ul> National Aggregate 2019 Percentiles: <sup>5</sup> <ul style="list-style-type: none"> <li>• Adult: 60.0</li> <li>• Child: 73.0</li> </ul>

*Notes.* <sup>1</sup> Prior to January 1, 2010, the EQRO calculated Texas MMC program measures each SFY. Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1-December 31). As a result, pre- and post-periods for Texas MMC program measures do not align with DYs. <sup>2</sup> The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative evaluation report. <sup>3</sup> Member subgroups may not be available for all years. <sup>4</sup> Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: <https://thlcportal.com/measures/cmsscoremeasuredashboard>. <sup>5</sup> National aggregate rates available via the CAHPS® Online Reporting System: <https://cahpsdatabase.ahrq.gov/CAHPSIDB/HP/about.aspx>. CAHPS®=Consumer Assessment of Healthcare Providers and Systems; STAR=MMC program for children, newborns, and pregnant women; STAR+PLUS=MMC program for individuals 21 and older with disabilities and individuals age 65 and older; STAR Kids=MMC program serving disabled individuals 20 years and younger; AHRQ=Agency for Healthcare Research and Quality; EQRO=External Quality Review Organization; MMC=Medicaid managed care; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; SFY=State Fiscal Year, September 1-August 31; DY=Demonstration year, October 1-September 30.

<b>Measure 2.5.2</b>	<b>Getting needed care composite (CAHPS®)</b>
<b>Definition</b>	The percentage of members or caregivers who report “always” being able to get needed care.
<b>Study Population</b>	STAR; STAR+PLUS; STAR Kids
<b>Measure Steward or Source</b>	AHRQ: Health Plan Survey 5.0H - Adult and Child Version (Medicaid) Including Medicaid and Children with Chronic Conditions Supplemental Items
<b>Technical Specifications</b>	<p><b>Members:</b> The percentage of member respondents who answered “Always” to the following questions:</p> <ul style="list-style-type: none"> <li>• In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?</li> <li>• In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?</li> </ul> <p><b>Caregivers:</b> The percentage of caregiver respondents who answered “Always” to the following questions:</p> <ul style="list-style-type: none"> <li>• In the last 6 months, how often did you get an appointment for your child to see a specialist as soon as you needed?</li> <li>• In the last 6 months, how often was it easy to get the care, tests, or treatment your child needed?</li> </ul> <p>Survey results are weighted to account for the probability of selection into the survey sample and potential response bias by members’ race/ethnicity. The Getting Needed Care composite score is the average percentage of member/caregiver respondents who answered “Always” across the two questions. The composite score is calculated using weighted counts.</p>
<b>Exclusion Criteria</b>	Members or caregivers who do not answer getting needed care questions
<b>Data Source(s)/Data Collection Methods</b>	EQRO-calculated MMC performance measures
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:</p> <ul style="list-style-type: none"> <li>• STAR Post Only: 1/1/2012 - 12/31/2029<sup>1,2</sup></li> <li>• STAR+PLUS Pre: 9/1/2008 - 12/31/2011</li> <li>• STAR+PLUS Post: 1/1/2012 - 12/31/2029</li> <li>• STAR Kids Post Only: 1/1/2018 - 12/31/2029</li> </ul> <p>Member characteristics (gender, race/ethnicity, region, etc.), where applicable<sup>3</sup></p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>



<b>Measure 2.5.2</b>	<b>Getting needed care composite (CAHPS®)</b>
<b>Interpretation</b>	Increases in the rates under this measure over time would suggest MMC members experienced improvements in MMC members' experience getting care.
<b>Benchmark</b>	<p>Texas CMS Core Measure, 2019 Medicaid State Rate:<sup>4</sup></p> <ul style="list-style-type: none"> <li>• Adult: 54.4</li> <li>• Child: 68.2</li> </ul> <p>National Aggregate 2019 Percentiles:<sup>5</sup></p> <ul style="list-style-type: none"> <li>• Adult: 56.0</li> <li>• Child: 61.0</li> </ul>

*Notes.* <sup>1</sup> Prior to January 1, 2010, the EQRO calculated Texas MMC program measures each SFY. Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1-December 31). As a result, pre- and post-periods for Texas MMC program measures do not align with DYs. <sup>2</sup> The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative evaluation report. <sup>3</sup> Member subgroups may not be available for all years. <sup>4</sup> Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: <https://thlcportal.com/measures/cmscoremeasuredashboard>. <sup>5</sup> National aggregate rates available via the CAHPS® Online Reporting System: <https://cahpsdatabase.ahrq.gov/CAHPSIDB/HP/about.aspx>. CAHPS®=Consumer Assessment of Healthcare Providers and Systems; STAR=MMC program for children, newborns, and pregnant women; STAR+PLUS=MMC program for individuals 21 and older with disabilities and individuals age 65 and older; STAR Kids=MMC program serving disabled individuals 20 years and younger; AHRQ=Agency for Healthcare Research and Quality; EQRO=External Quality Review Organization; MMC=Medicaid managed care; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; SFY=State Fiscal Year, September 1-August 31; DY=Demonstration year, October 1-September 30.

<b>Measure 2.5.3</b>	<b>Rating of personal doctor (CAHPS®)</b>
<b>Definition</b>	The rating members and caregivers provide of their personal doctor.
<b>Study Population</b>	STAR; STAR+PLUS; STAR Kids
<b>Measure Steward or Source</b>	AHRQ: Health Plan Survey 5.0H - Adult and Child Version (Medicaid) Including Medicaid and Children with Chronic Conditions Supplemental Items



<b>Measure 2.5.3</b>	<b>Rating of personal doctor (CAHPS®)</b>
<b>Technical Specifications</b>	<p><b>Members:</b> The percentage of member respondents who rate their personal doctor at a 9 or 10 on a scale of 0 to 10, with 0 being the worst and 10 being the best</p> <p><b>Caregivers:</b> The percentage of caregiver respondents who rate their child's personal doctor at a 9 or 10 on a scale of 0 to 10, with 0 being the worst and 10 being the best</p> <p>Survey results are weighted to account for the probability of selection into the survey sample and potential response bias by members' race/ethnicity.</p>
<b>Exclusion Criteria</b>	Members or caregivers who do not provide a rating
<b>Data Source(s)/Data Collection Methods</b>	EQRO-calculated MMC performance measures
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:</p> <ul style="list-style-type: none"> <li>• STAR Post Only: 1/1/2012 - 12/31/2029<sup>1,2</sup></li> <li>• STAR+PLUS Pre: 9/1/2008 - 12/31/2011</li> <li>• STAR+PLUS Post: 1/1/2012 - 12/31/2029</li> <li>• STAR Kids Post Only: 1/1/2018 - 12/31/2029</li> </ul> <p>Member characteristics (gender, race/ethnicity, region, etc.), where applicable<sup>3</sup></p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	Increases in the rates under this measure over time would suggest MMC members experienced improvements in MMC members' perceptions of their personal doctor.
<b>Benchmark</b>	<p>Texas CMS Core Measure, 2019 Medicaid State Rate:<sup>4</sup></p> <ul style="list-style-type: none"> <li>• Adult: 67.7</li> <li>• Child: 82.8</li> </ul> <p>National Aggregate 2019 Percentiles:<sup>5</sup></p> <ul style="list-style-type: none"> <li>• Adult: 67.0</li> <li>• Child: 77.0</li> </ul>

*Notes.* <sup>1</sup> Prior to January 1, 2010, the EQRO calculated Texas MMC program measures each SFY. Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1-December 31). As a result, pre- and post-periods for Texas MMC program measures do not align with DYS. <sup>2</sup> The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative evaluation report. <sup>3</sup> Member subgroups may not be available for all years. <sup>4</sup> Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: <https://thlcportal.com/measures/cmscoremeasuredashboard>. <sup>5</sup> National aggregate rates available via the CAHPS® Online Reporting System: <https://cahpsdatabase.ahrq.gov/CAHPSIDB/HP/about.aspx>. CAHPS®=Consumer Assessment of Healthcare Providers and Systems; STAR=MMC program for children, newborns, and pregnant women; STAR+PLUS=MMC

program for individuals 21 and older with disabilities and individuals age 65 and older; STAR Kids=MMC program serving disabled individuals 20 years and younger; AHRQ=Agency for Healthcare Research and Quality; EQRO=External Quality Review Organization; MMC=Medicaid managed care; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; SFY=State Fiscal Year, September 1-August 31; DY=Demonstration year, October 1-September 30.

<b>Measure 2.5.4</b>	<b>Rating of health plan (CAHPS®)</b>
<b>Definition</b>	The rating members and caregivers provide of their health plan.
<b>Study Population</b>	STAR; STAR+PLUS; STAR Kids
<b>Measure Steward or Source</b>	AHRQ: Health Plan Survey 5.0H - Adult and Child Version (Medicaid) Including Medicaid and Children with Chronic Conditions Supplemental Items
<b>Technical Specifications</b>	<p><b>Members:</b> The percentage of member respondents who rate their health plan at a 9 or 10 on a scale of 0 to 10, with 0 being the worst and 10 being the best</p> <p><b>Caregivers:</b> The percentage of caregiver respondents who rate their child's health plan at a 9 or 10 on a scale of 0 to 10, with 0 being the worst and 10 being the best</p> <p>Survey results are weighted to account for the probability of selection into the survey sample and potential response bias by members' race/ethnicity.</p>
<b>Exclusion Criteria</b>	Members or caregivers who do not provide a rating
<b>Data Source(s)/Data Collection Methods</b>	EQRO-calculated MMC performance measures
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:</p> <ul style="list-style-type: none"> <li>• STAR Post Only: 1/1/2012 - 12/31/2029<sup>1,2</sup></li> <li>• STAR+PLUS Pre: 9/1/2008 - 12/31/2011</li> <li>• STAR+PLUS Post: 1/1/2012 - 12/31/2029</li> <li>• STAR Kids Post Only: 1/1/2018 - 12/31/2029</li> </ul> <p>Member characteristics (gender, race/ethnicity, region, etc.), where applicable<sup>3</sup></p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	Increases in the rates under this measure over time would suggest MMC members experienced improvements in MMC members' perceptions of their health plan.

Measure 2.5.4	Rating of health plan (CAHPS®)
<b>Benchmark</b>	<p>Texas CMS Core Measure, 2019 Medicaid State Rate:<sup>4</sup></p> <ul style="list-style-type: none"> <li>Adult: 56.9</li> <li>Child: 82.4</li> </ul> <p>National Aggregate 2019 Percentiles:<sup>5</sup></p> <ul style="list-style-type: none"> <li>Adult: 60.0</li> <li>Child: 71.0</li> </ul>

*Notes.* <sup>1</sup> Prior to January 1, 2010, the EQRO calculated Texas MMC program measures each SFY. Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1-December 31). As a result, pre- and post-periods for Texas MMC program measures do not align with DYs. <sup>2</sup> The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. Availability of this measure through December 31, 2029 is contingent on continuity in the EQRO's calculation and reporting of the measure. The external evaluator may extend the post-period if additional data become available prior to the Summative evaluation report. <sup>3</sup> Member subgroups may not be available for all years. <sup>4</sup> Texas CMS Core Measure rates available via the Texas Healthcare Learning Collaborative Portal: <https://thlcportal.com/measures/cmscoremeasuredashboard>. <sup>5</sup> National aggregate rates available via the CAHPS® Online Reporting System: <https://cahpsdatabase.ahrq.gov/CAHPSIDB/HP/about.aspx>. CAHPS®=Consumer Assessment of Healthcare Providers and Systems; STAR=MMC program for children, newborns, and pregnant women; STAR+PLUS=MMC program for individuals 21 and older with disabilities and individuals age 65 and older; STAR Kids=MMC program serving disabled individuals 20 years and younger; AHRQ=Agency for Healthcare Research and Quality; EQRO=External Quality Review Organization; MMC=Medicaid managed care; DTA=Descriptive trend analysis; CMS=Centers for Medicare and Medicaid Services; SFY=State Fiscal Year, September 1-August 31; DY=Demonstration year, October 1-September 30.

### Evaluation Question 3: Did Texas's quality initiatives impact the development and implementation of quality-based payment systems?

#### H3.1. The implementation of APMs in Texas Medicaid will increase over time.

Measure 3.1.1	Percentage of providers implementing APMs
<b>Definition</b>	The percentage of DPP providers implementing APMs.
<b>Study Population</b>	DPP Providers
<b>Measure Steward or Source</b>	N/A
<b>Technical Specifications</b>	The percentage of DPP providers self-reporting implementing at least one APM.
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>Provider survey</li> </ul>

<b>Measure 3.1.1</b>	<b>Percentage of providers implementing APMs</b>
<b>Comparison Group(s)/ Subgroup(s)</b>	Separated by the Health Care Payment Learning & Action Network APM categories and subcategories, if feasible. APM categories are accessible via: <a href="https://hcp-lan.org/apm-refresh-white-paper/">https://hcp-lan.org/apm-refresh-white-paper/</a>  Provider characteristics (provider type, region, etc.), where applicable
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA, including DY7-11 data, if feasible</li> </ul>
<b>Interpretation</b>	This measure is a direct indicator of APM implementation.
<b>Benchmark</b>	None

Notes. APM=Alternative payment model; DPP=Directed Payment Program; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30.

<b>Measure 3.1.2</b>	<b>Percentage of MCOs and providers implementing risk-based APMs</b>
<b>Definition</b>	The percentage of MCOs and DPP providers implementing risk-based APMs.
<b>Study Population</b>	MCOs; DPP Providers
<b>Measure Steward or Source</b>	N/A
<b>Technical Specifications</b>	The percentage of MCOs implementing and the providers self-reporting implementing at-risk APMs.
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• MCO APM reporting tool</li> <li>• Provider survey</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	Separated by the Health Care Payment Learning & Action Network APM categories and subcategories, if feasible. APM categories are accessible via: <a href="https://hcp-lan.org/apm-refresh-white-paper/">https://hcp-lan.org/apm-refresh-white-paper/</a>  MCO and provider characteristics (MMC program, MCO size, provider type, region, etc.), where applicable
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA, including DY7-11 data, if feasible</li> </ul>
<b>Interpretation</b>	This measure is a direct indicator of APM implementation.
<b>Benchmark</b>	None

Notes. MCO=Managed care organization; APM=Alternative payment model; DPP=Directed Payment Program; MMC=Medicaid managed care; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30.

<b>Measure 3.1.3</b>	<b>Percentage of MCO payments made through APMs</b>
<b>Definition</b>	The percentage of total MCO payments made to providers through APMs.
<b>Study Population</b>	MCOs
<b>Measure Steward or Source</b>	N/A
<b>Technical Specifications</b>	HHSC contractually requires MCOs to establish APMs with providers. By December 31, 2021, MCOs are expected to have at least 50 percent of total provider payments for medical and prescription expenses in APMs, and at least 25 percent in a risk-based model. MCOs are required to report on total provider payments in APMs and risk-based models by July 1, 2022. HHSC may establish new APM targets for MCOs after December 31, 2021.
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>MCO APM reporting tool</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Separated by the Health Care Payment Learning &amp; Action Network APM categories and subcategories, if feasible. APM categories are accessible via: <a href="https://hcp-lan.org/apm-refresh-white-paper/">https://hcp-lan.org/apm-refresh-white-paper/</a></p> <p>MCO and provider characteristics (MMC program, MCO size, provider type, region, etc.), where applicable</p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA, including DY7-11 data, if feasible</li> </ul>
<b>Interpretation</b>	This measure is a direct indicator of APM implementation.
<b>Benchmark</b>	None

*Notes.* MCO=Managed care organization; APM=Alternative payment model; HHSC=Health and Human Services Commission; MMC=Medicaid managed care; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30.

<b>Measure 3.1.4</b>	<b>Perceived benefits of implementing APMs</b>
<b>Definition</b>	MCO and DPP provider-identified benefits, or perceived successes, of implementing APMs within the Texas MMC delivery model.
<b>Study Population</b>	MCOs; DPP Providers
<b>Measure Steward or Source</b>	N/A
<b>Technical Specifications</b>	Open-ended responses on perceived benefits of implementing APMs.
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>MCO survey</li> <li>Provider survey</li> </ul>

<b>Measure 3.1.4</b>	<b>Perceived benefits of implementing APMs</b>
<b>Comparison Group(s)/ Subgroup(s)</b>	MCO and provider characteristics (MMC program, MCO size, provider type, region, etc.), where applicable
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Content analysis</li> <li>• Thematic content analysis</li> </ul>
<b>Interpretation</b>	Respondent perspectives will provide direct insight into successes of implementing APMs in Texas.
<b>Benchmark</b>	None

*Notes.* APM=Alternative payment model; MCO=Managed care organization; DPP=Directed Payment Program; MMC=Medicaid managed care.

<b>Measure 3.1.5</b>	<b>Perceived challenges with implementing APMs</b>
<b>Definition</b>	MCOs and DPP provider-identified challenges, or perceived drawbacks, experienced implementing APMs within Texas MMC delivery model.
<b>Study Population</b>	MCOs; DPP Providers
<b>Measure Steward or Source</b>	N/A – External evaluator will develop survey
<b>Technical Specifications</b>	Open-ended responses on challenges or perceived drawbacks to the implementation of APMs.
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	MCO survey Provider survey
<b>Comparison Group(s)/ Subgroup(s)</b>	MCO and provider characteristics (MMC program, MCO size, provider type, region, etc.), where applicable
<b>Analytic Methods</b>	Content analysis Thematic content analysis
<b>Interpretation</b>	Respondent perspectives will provide direct insight into barriers implementing APMs in Texas.
<b>Benchmark</b>	None

*Notes.* APM=Alternative payment model; MCO=Managed care organization; DPP=Directed Payment Program; MMC=Medicaid managed care.

## DPP Component

### Evaluation Question 4. Do DPPs continue or expand upon the successful innovations of DSRIP?

#### H4.1. DPPs continue or expand upon DSRIP best practices.

Measure 4.1.1	SDA learning collaborative participation
<b>Definition</b>	The percentage of CHIRP providers who report participating in a learning collaborative hosted by a regional anchor entity.
<b>Study Population</b>	CHIRP providers
<b>Measure Steward or Source</b>	N/A
<b>Technical Specifications</b>	<b>Numerator:</b> Number of providers who report participation in a learning collaborative <b>Denominator:</b> Number of providers in CHIRP <b>Rate:</b> (Numerator / Denominator) * 100
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>DPP reporting</li> <li>Provider-level eligibility files</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	Provider characteristics (provider type, region, etc.), where applicable
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> </ul>
<b>Interpretation</b>	As part of the DSRIP Transition, the Best Practices Workgroup identified SDA learning collaborative participation as a DSRIP best practice. As a result, this measure is a direct indicator of DPP providers continuing or expanding upon DSRIP best practices.
<b>Benchmark</b>	None

Notes. SDA=Service Delivery Area; CHIRP=Comprehensive Hospital Increased Reimbursement Program; DPP=Directed Payment Program; DTA=Descriptive trend analysis; DSRIP=Delivery System Reform Incentive Payment.

Measure 4.1.2	Care team includes personnel in a care coordination role not requiring clinical licensure
<b>Definition</b>	The percentage of RAPPS and TIPPS providers who report their care team includes personnel in a care coordination role not requiring clinical licensure.
<b>Study Population</b>	RAPPS providers; TIPPS providers
<b>Measure Steward or Source</b>	N/A



<b>Measure 4.1.2</b>	<b>Care team includes personnel in a care coordination role not requiring clinical licensure</b>
<b>Technical Specifications</b>	<p><b>Numerator:</b> Number of providers who report their care team includes personnel in a care coordination role not requiring clinical licensure</p> <p><b>Denominator:</b> Number of providers in DPP</p> <p><b>Rate:</b> (Numerator / Denominator) * 100</p> <p>The rate will be calculated separately for RAPPs and TIPPS.</p>
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• DPP reporting</li> <li>• Provider-level eligibility files</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	Participating DPP (RAPPs, TIPPS) Provider characteristics (provider type, region, etc.), where applicable
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	As part of the DSRIP Transition, the Best Practices Workgroup identified having a care team with certain personnel, including a care coordinator, as a DSRIP best practice. As a result, this measure is a direct indicator of DPP providers continuing or expanding upon DSRIP best practices.
<b>Benchmark</b>	None

Notes. RAPPs=Rural Access to Primary and Preventive Services; TIPPS=Texas Incentives for Physician and Professional Services; DPP=Directed Payment Program; DTA=Descriptive trend analysis; DSRIP=Delivery System Reform Incentive Payment.

<b>Measure 4.1.3</b>	<b>Same-day, walk-in, or after-hours appointments in the outpatient setting</b>
<b>Definition</b>	The percentage of TIPPS providers who report availability of same-day, walk-in, or after-hours appointments.
<b>Study Population</b>	TIPPS providers
<b>Measure Steward or Source</b>	N/A
<b>Technical Specifications</b>	<p><b>Numerator:</b> Number of providers who report availability of same-day, walk-in, or after-hours appointments</p> <p><b>Denominator:</b> Number of providers in DPP</p> <p><b>Rate:</b> (Numerator / Denominator) * 100</p>
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• DPP reporting</li> <li>• Provider-level eligibility files</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	Provider characteristics (provider type, region, etc.), where applicable



<b>Measure 4.1.3</b>	<b>Same-day, walk-in, or after-hours appointments in the outpatient setting</b>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	As part of the DSRIP Transition, the Best Practices Workgroup identified the availability of same-day walk-in or after-hours appointments in the outpatient setting as a DSRIP best practice. As a result, this measure is a direct indicator of DPP providers continuing or expanding upon DSRIP best practices.
<b>Benchmark</b>	None

Notes. TIPPS=Texas Incentives for Physician and Professional Services; DPP=Directed Payment Program; DTA=Descriptive trend analysis; DSRIP=Delivery System Reform Incentive Payment.

<b>Measure 4.1.4</b>	<b>Pre-visit planning and/or standing order protocols</b>
<b>Definition</b>	The percentage of TIPPS providers who report having processes in place for pre-visit planning and/or standing order protocols.
<b>Study Population</b>	TIPPS providers
<b>Measure Steward or Source</b>	N/A
<b>Technical Specifications</b>	<b>Numerator:</b> Number of providers who report processes for pre-visit planning and/or standing order protocols <b>Denominator:</b> Number of providers in DPP <b>Rate:</b> (Numerator / Denominator) * 100
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• DPP reporting</li> <li>• Provider-level eligibility files</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	Provider characteristics (provider type, region, etc.), where applicable
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	As part of the DSRIP Transition, the Best Practices Workgroup identified having pre-visit planning and/or standing order protocols as a DSRIP best practice. As a result, this measure is a direct indicator of DPP providers continuing or expanding upon DSRIP best practices.
<b>Benchmark</b>	None

Notes. TIPPS=Texas Incentives for Physician and Professional Services; DPP=Directed Payment Program; DTA=Descriptive trend analysis; DSRIP=Delivery System Reform Incentive Payment.

<b>Measure 4.1.5</b>	<b>Provide patients with services by using remote technology</b>
<b>Definition</b>	The percentage of DPP BHS providers who report using remote technology, including audio/video, client portals, and apps for the provision of services such as telehealth, assessment collection, and remote health monitoring/screening.
<b>Study Population</b>	DPP BHS providers
<b>Measure Steward or Source</b>	N/A
<b>Technical Specifications</b>	<b>Numerator:</b> Number of providers who report on the use of remote technology <b>Denominator:</b> Number of providers in DPP <b>Rate:</b> (Numerator / Denominator) * 100
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• DPP reporting</li> <li>• Provider-level eligibility files</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	Provider characteristics (provider type, region, etc.), where applicable
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	As part of the DSRIP Transition, the Best Practices Workgroup identified the use of remote technology as a DSRIP best practice. As a result, this measure is a direct indicator of DPP providers continuing or expanding upon DSRIP best practices.
<b>Benchmark</b>	None

*Notes.* DPP BHS=Directed Payment Program for Behavioral Health Services; DPP=Directed Payment Program; DTA=Descriptive trend analysis; DSRIP=Delivery System Reform Incentive Payment.

#### H4.2. DPPs support providers' transition from DSRIP.

<b>Measure 4.2.1</b>	<b>Number of DPP providers</b>
<b>Definition</b>	The unique count of providers enrolled in each DPP each SFY.
<b>Study Population</b>	DPP providers
<b>Measure Steward or Source</b>	N/A

<b>Measure 4.2.1</b>	<b>Number of DPP providers</b>
<b>Technical Specifications</b>	<p>Unique count of providers enrolled in:</p> <ul style="list-style-type: none"> <li>• CHIRP</li> <li>• DPP BHS</li> <li>• RAPPs</li> <li>• TIPPS</li> <li>• QIPP</li> </ul> <p>Unique count of providers enrolled in any DPP each SFY (providers enrolled in multiple DPPs only counted once)</p>
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• DPP reporting</li> <li>• Provider-level eligibility files</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	Provider characteristics (provider type, region, etc.), where applicable
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	This measure is a direct indicator of the number of providers enrolled in DPPs each SFY.
<b>Benchmark</b>	None

*Notes.* DPP=Directed Payment Program; SFY=State Fiscal Year, September 1-August 31; CHIRP=Comprehensive Hospital Increase Reimbursement Program; DPP BHS=Directed Payment Program for Behavioral Health Services; RAPPs=Rural Access to Primary and Preventive Services; TIPPS=Texas Incentives for Physician and Professional Services; QIPP=Quality Incentive Payment Program; DTA=Descriptive trend analysis.

<b>Measure 4.2.2</b>	<b>Continuity of participation across DSRIP and DPPs</b>
<b>Definition</b>	The percentage of previous DSRIP providers who are enrolled in one of the DPPs.
<b>Study Population</b>	Previous DSRIP providers; DPP providers
<b>Measure Steward or Source</b>	N/A

Measure 4.2.2	Continuity of participation across DSRIP and DPPs
<b>Technical Specifications</b>	<p><i>Previous DSRIP Providers Engaged in DPPs:</i>  <b>Numerator 1:</b> Number of providers who were in DSRIP between DY 7-10<sup>1</sup> and are enrolled in any DPP in SFY 2022  <b>Denominator 1:</b> Number of providers who were in DSRIP between DY 7-10  <b>Rate 1:</b> (Numerator / Denominator) * 100</p> <p><i>DPP Providers Previously Engaged in DSRIP:</i>  <b>Numerator 2:</b> Number of providers who were in DSRIP between DY 7-10 and are enrolled in any DPP in SFY 2022  <b>Denominator 2:</b> Number of providers who are enrolled in any DPP in SFY 2022  <b>Rate 2:</b> (Numerator / Denominator) * 100  The external evaluator should recalculate rates for additional SFYs if DPP providers substantially change after the first year of implementation.</p>
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• DPP reporting</li> <li>• DSRIP reporting</li> <li>• Provider-level eligibility files</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	Participating DPP Provider characteristics (provider type, region, etc.), where applicable
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> </ul>
<b>Interpretation</b>	This measure is a direct indicator of the percentage of providers who transition from DSRIP to one or more DPPs.
<b>Benchmark</b>	None

Notes. <sup>1</sup> Only DYs 7-10 are included due to programmatic changes in DSRIP starting in DY 7. DSRIP=Delivery System Reform Incentive Payment; DPP=Directed Payment Program; DY=Demonstration Year, October 1-September 30; SFY=State Fiscal Year, September 1-August 31.

Measure 4.2.3	Incentive payments made to providers
<b>Definition</b>	The total amount paid to providers enrolled in DSRIP or a DPP per DY/SFY.
<b>Study Population</b>	Previous DSRIP providers; DPP providers
<b>Measure Steward or Source</b>	N/A

<b>Measure 4.2.3</b>	<b>Incentive payments made to providers</b>
<b>Technical Specifications</b>	<ul style="list-style-type: none"> <li>• Payments made to providers (unique TPI) per DY/SFY<sup>1</sup></li> <li>• Total payments made across all providers (across all TPIs) per DY/SFY</li> </ul> <p>Payments should be combined across DPPs for providers participating in more than one DPP.</p>
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• DSRIP reporting</li> <li>• HHSC-estimated DPP payment data</li> <li>• Provider-level eligibility files</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:<sup>2</sup></p> <ul style="list-style-type: none"> <li>• Pre: 10/1/2013- 9/30/2021</li> <li>• Post: 9/1/2021- 8/31/2022<sup>3</sup></li> </ul> <p>Separated by program membership, if feasible<sup>4</sup></p> <p>DPP characteristics (participating DPP, DPP incentive structure), where applicable</p> <p>Provider characteristics (provider type, region, etc.), where applicable</p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	No change or an increase in this measure following DPP implementation would suggest DPPs financially support providers after DSRIP ends.
<b>Benchmark</b>	None

*Notes.* <sup>1</sup> DSRIP operates on DYs, but DPP operate on SFYs. <sup>2</sup> Because DSRIP operates on DYs and DPP operate on SFYs, there will be a one-month overlap between the pre- and post-periods. <sup>3</sup> The initial preprints for the CHIRP, DPP BHS, RAPPs, and TIPPS are applicable through August 31, 2022; QIPP is approved through August 31, 2022. Should CMS approve additional years of DPP implementation, the DPP evaluation component will be expanded to include additional years of data. <sup>4</sup> Program membership may reflect DSRIP providers who did not enroll in a DPP, DSRIP providers who did enroll in a DPP, and DPP providers who were not previously enrolled in DSRIP. DSRIP=Delivery System Reform Incentive Payment; DPP=Directed Payment Program; DY=Demonstration year, October 1-September 30; SFY=State Fiscal Year, September 1-August 31; TPI=Texas Provider Identifier; HHSC=Health and Human Services Commission; DTA=Descriptive trend analysis; CHIRP=Comprehensive Hospital Increase Reimbursement Program; DPP BHS=Directed Payment Program for Behavioral Health Services; RAPPs=Rural Access to Primary and Preventive Services; TIPPS=Texas Incentives for Physician and Professional Services; QIPP=Quality Incentive Payment Program; CMS=Centers for Medicare and Medicaid Services.

<b>Measure 4.2.4</b>	<b>Perceived successes and challenges of DPPs</b>
<b>Definition</b>	Perceived successes and challenges of DPPs in supporting: <ul style="list-style-type: none"> <li>• DSRIP innovations</li> <li>• Provider operations</li> <li>• Provider sustainability</li> </ul>
<b>Study Population</b>	DPP providers who participated in DSRIP
<b>Measure Steward or Source</b>	N/A – External evaluator will develop survey
<b>Technical Specifications</b>	DPP providers who participated in DSRIP will be asked to provide feedback on the successes and challenges of DPPs in supporting DSRIP innovations, provider operations, and provider sustainability.
<b>Exclusion Criteria</b>	N/A – External evaluator will develop survey
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• Provider Survey (to be developed by external evaluator)</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	DPP characteristics (participating DPP, DPP incentive structure), where applicable Respondent characteristics (provider type, region, etc.), where applicable
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Thematic content analysis</li> </ul>
<b>Interpretation</b>	Respondent perspectives will provide direct insight into the successes and challenges of DPPs in supporting DSRIP innovations, provider operations, and provider sustainability.
<b>Benchmark</b>	None

Notes. DPP=Directed Payment Program; DSRIP=Delivery System Reform Incentive Payment.

<b>Measure 4.2.5</b>	<b>Provider perspectives on state priorities and policy development</b>
<b>Definition</b>	Provider perspectives on and recommendations for state priorities and policy development related to innovations advanced through DSRIP and DPPs.
<b>Study Population</b>	DPP providers who participated in DSRIP
<b>Measure Steward or Source</b>	N/A – External evaluator will develop survey
<b>Technical Specifications</b>	DPP program providers will be asked to share perspectives on and recommendations for state priorities and policy development related to innovations advanced through DSRIP and DPPs.
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• Provider Survey (to be developed by external evaluator)</li> </ul>

<b>Measure 4.2.5</b>	<b>Provider perspectives on state priorities and policy development</b>
<b>Comparison Group(s)/ Subgroup(s)</b>	DPP characteristics (participating DPP, DPP incentive structure), where applicable Respondent characteristics (provider type, region, etc.), where applicable
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>Thematic content analysis</li> </ul>
<b>Interpretation</b>	Respondent perspectives will provide direct insight into how DPPs can continue and expand upon successful innovations of DSRIP and DPPs.
<b>Benchmark</b>	None

Notes. DSRIP=Delivery System Reform Incentive Payment; DPP=Directed Payment Program.

## **Evaluation Question 5. Do DPPs advance at least one of the goals in the managed care quality strategy?**

### **H5.1. DPPs promote optimal health for Texans.**

<b>Measure 5.1.1</b>	<b>Maternity care: Postpartum follow-up and care coordination</b>
<b>Definition</b>	The percentage of patients who gave birth, who were seen for postpartum visit within 8 weeks of giving birth, and who received: a breast-feeding evaluation and education, postpartum depression screening, postpartum glucose screening for gestational diabetes patients, and family and contraceptive planning.
<b>Study Population</b>	TIPPS clients
<b>Measure Steward or Source</b>	CMS

<b>Measure 5.1.1</b>	<b>Maternity care: Postpartum follow-up and care coordination</b>
<b>Technical Specifications</b>	<p><b>Numerator:</b> Patients receiving each of the following services at a postpartum visit before or at 8 weeks postpartum:</p> <ul style="list-style-type: none"> <li>• Breast-feeding evaluation and education, including patient-reported breast-feeding</li> <li>• Postpartum depression screening</li> <li>• Postpartum glucose screening for gestational diabetes patients</li> <li>• Family and contraceptive planning counseling</li> <li>• Tobacco use screening and cessation education</li> <li>• Healthy lifestyle behavioral advice</li> <li>• Immunization review and update</li> </ul> <p><b>Denominator:</b> Patients, regardless of age, who gave birth during a 12-month period seen for postpartum care visit before or at 8 weeks of giving birth</p> <p><b>Rate:</b> (Numerator / Denominator) * 100</p> <p>Providers in TIPPS will report this measure semi-annually: once in October and once in April.</p>
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• DPP reporting</li> <li>• DSRIP reporting</li> <li>• Provider-level eligibility files</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:<sup>1</sup></p> <ul style="list-style-type: none"> <li>• Pre: 10/1/2013- 9/30/2021</li> <li>• Post: 9/1/2021- 8/31/2022<sup>2</sup></li> </ul> <p>Separated by payer source (Medicaid, other insurance, other), if feasible</p> <p>Provider characteristics (provider type, region, etc.), where applicable</p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	No change or an increase in this measure following DPP implementation would suggest TIPPS promotes postpartum care for Texans.
<b>Benchmark</b>	None

*Notes.* <sup>1</sup> Because DSRIP operates on DYs and DPP operate on SFYs, there will be a one-month overlap between the pre- and post-periods. <sup>2</sup> The initial preprints for the CHIRP, DPP BHS, RAPPS, and TIPPS are applicable through August 31, 2022; QIPP is approved through August 31, 2022. Should CMS approve additional years of DPP implementation, the DPP evaluation component will be expanded to include additional years of data. TIPPS=Texas Incentives for Physician and Professional Services; CMS=Centers for Medicare and Medicaid Services; DPP=Directed Payment Program; DSRIP=Delivery System Reform Incentive Payment;



DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30; SFY=State Fiscal Year, September 1-August 31; CHIRP=Comprehensive Hospital Increase Reimbursement Program; DPP BHS=Directed Payment Program for Behavioral Health Services; RAPPs=Rural Access to Primary and Preventive Services; QIPP=Quality Incentive Payment Program.

<b>Measure 5.1.2</b>	<b>Childhood immunization status (HEDIS®)</b>
<b>Definition</b>	<p>The percentage of children age 2 who received the following vaccines by their 2<sup>nd</sup> birthday:</p> <ul style="list-style-type: none"> <li>• Four diphtheria, tetanus and acellular pertussis (DTaP);</li> <li>• Three polio (IPV);</li> <li>• One measles, mumps and rubella (MMR);</li> <li>• Three haemophilus influenza type B (HiB);</li> <li>• Three hepatitis B (HepB);</li> <li>• One chicken pox (VZV);</li> <li>• Four pneumococcal conjugate (PCV);</li> <li>• One hepatitis A (HepA);</li> <li>• Two or three rotavirus (RV); and</li> <li>• Two influenza</li> </ul>
<b>Study Population</b>	TIPPS clients
<b>Measure Steward or Source</b>	NCQA (HEDIS®) measure: Childhood immunization status (CIS)
<b>Technical Specifications</b>	<p><b>Numerator:</b> Children who have evidence showing they received recommended vaccines, had documented history of the illness, had a seropositive test result, or had an allergic reaction to the vaccine by their 2<sup>nd</sup> birthday</p> <p><b>Denominator:</b> Children who turn 2 years of age during the measurement period and who have a visit during the measurement period</p> <p><b>Rate:</b> (Numerator / Denominator) * 100</p> <p>Providers in TIPPS will report this measure semi-annually: once in October and once in April.</p>
<b>Exclusion Criteria</b>	Patients whose hospice care overlaps the measurement period
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• DPP reporting</li> <li>• DSRIP reporting</li> <li>• Provider-level eligibility files</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:<sup>1</sup></p> <ul style="list-style-type: none"> <li>• Pre: 10/1/2013- 9/30/2021</li> <li>• Post: 9/1/2021- 8/31/2022<sup>2</sup></li> </ul> <p>Separated by payer source (Medicaid, other insurance, other), if feasible</p> <p>Provider characteristics (provider type, region, etc.), where applicable</p>

<b>Measure 5.1.2</b>	<b>Childhood immunization status (HEDIS®)</b>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	No change or an increase in this measure following DPP implementation would suggest TIPPS promotes access to preventive care for children.
<b>Benchmark</b>	NCQA Quality Compass 2020, 50 <sup>th</sup> Percentile Benchmark: 37.5

*Notes.* <sup>1</sup> Because DSRIP operates on DYs and DPP operate on SFYs, there will be a one-month overlap between the pre- and post-periods. <sup>2</sup> The initial preprints for the CHIRP, DPP BHS, RAPPs, and TIPPS are applicable through August 31, 2022; QIPP is approved through August 31, 2022. Should CMS approve additional years of DPP implementation, the DPP evaluation component will be expanded to include additional years of data. HEDIS®=Healthcare Effectiveness Data and Information Set; DTA=Diphtheria, tetanus and acellular pertussis; IPV=Inactivated polio vaccine; MMR=Measles, mumps, and rubella; HiB=Haemophilus influenza type B; HepB=Hepatitis B; VZV=Varicella-zoster virus; PCV=Pneumococcal conjugate virus; HepA=Hepatitis A; RV=Rotavirus; TIPPS=Texas Incentives for Physician and Professional Services; NCQA=National Committee for Quality Assurance; DPP=Directed Payment Program; DSRIP=Delivery System Reform Incentive Payment; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30; SFY=State Fiscal Year, September 1-August 31; CHIRP=Comprehensive Hospital Increase Reimbursement Program; DPP BHS=Directed Payment Program for Behavioral Health Services; RAPPs=Rural Access to Primary and Preventive Services; QIPP=Quality Incentive Payment Program; CMS=Centers for Medicare and Medicaid Services.

<b>Measure 5.1.3</b>	<b>Preventive care and screening: Influenza immunization</b>
<b>Definition</b>	The percentage of patients aged 6 months and older seen for a visit during the measurement period who received an influenza immunization or who reported previous receipt of an influenza immunization.
<b>Study Population</b>	CHIRP clients; RAPPs clients; TIPPS clients; QIPP residents
<b>Measure Steward or Source</b>	Physician Consortium for Performance Improvement® Foundation / American Medical Association
<b>Technical Specifications</b>	<p><b>Numerator:</b> Patients who received an influenza immunization or who reported previous receipt of an influenza immunization</p> <p><b>Denominator:</b> All patients aged 6 months and older seen for a visit during the measurement period, and seen for a visit during the measurement period</p> <p><b>Rate:</b> (Numerator / Denominator) * 100</p> <p>Providers in CHIRP, RAPPs, and TIPPS will report this measure semi-annually: once in October and once in April.</p>
<b>Exclusion Criteria</b>	Documentation of medical reason(s) for not receiving influenza immunization (e.g., patient allergy, patient declined, vaccine not available)

<b>Measure 5.1.3</b>	<b>Preventive care and screening: Influenza immunization</b>
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• DPP reporting</li> <li>• DSRIP reporting</li> <li>• Long-stay MDS data</li> <li>• Provider-level eligibility files</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>CHIRP, RAPPS, and TIPPS pre-post comparison:<sup>1</sup></p> <ul style="list-style-type: none"> <li>• Pre: 10/1/2013- 9/30/2021</li> <li>• Post: 9/1/2021- 8/31/2022<sup>2</sup></li> </ul> <p>QIPP post only: 9/1/2017- 8/31/2022<sup>2</sup></p> <p>Separated by payer source (Medicaid, other insurance, other), if feasible</p> <p>DPP characteristics (participating DPP, DPP incentive structure), where applicable</p> <p>Provider characteristics (provider type, region, etc.), where applicable</p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	<p><b>CHIRP, RAPPS, and TIPPS:</b> No change or an increase in this measure following DPP implementation would suggest CHIRP, RAPPS, and TIPPS promote access to preventive care for Texans.</p> <p><b>QIPP:</b> An increase in this measure over time would suggest QIPP improves access to preventive care for individuals residing in nursing facilities.</p>
<b>Benchmark</b>	None

*Notes.* <sup>1</sup> Because DSRIP operates on DYs and DPP operate on SFYs, there will be a one-month overlap between the pre- and post-periods. <sup>2</sup> The initial preprints for the CHIRP, DPP BHS, RAPPS, and TIPPS are applicable through August 31, 2022; QIPP is approved through August 31, 2022. Should CMS approve additional years of DPP implementation, the DPP evaluation component will be expanded to include additional years of data. CHIRP=Comprehensive Hospital Increased Rate Program; RAPPS=Rural Access to Primary and Preventive Services; TIPPS=Texas Incentives for Physician and Professional Services; QIPP=Quality Incentive Payment Program; DPP=Directed Payment Program; DSRIP=Delivery System Reform Incentive Payment; MDS=Minimum Data Set; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30; SFY=State Fiscal Year, September 1-August 31; DPP BHS=Directed Payment Program for Behavioral Health Services; CMS=Centers for Medicare and Medicaid Services.

<b>Measure 5.1.4</b>	<b>Comprehensive diabetes care: Hemoglobin A1c (HbA1c) testing (HEDIS®)</b>
<b>Definition</b>	The percentage of patients ages 18 to 75 with diabetes (type 1 and type 2) who had a hemoglobin A1c (HbA1c) test.
<b>Study Population</b>	RAPPS clients; TIPPS clients

<b>Measure 5.1.4</b>	<b>Comprehensive diabetes care: Hemoglobin A1c (HbA1c) testing (HEDIS®)</b>
<b>Measure Steward or Source</b>	NCQA (HEDIS®) measure: Comprehensive diabetes care (CDC)
<b>Technical Specifications</b>	<p><b>Numerator:</b> An HbA1c test performed during the measurement year, as identified by claim/encounter or automated laboratory data</p> <p><b>Denominator:</b> Patients ages 18 to 75 as of December 31 of the measurement year</p> <p><b>Rate:</b> (Numerator / Denominator) * 100</p> <p>Providers in RAPPs and TIPPS will report this measure semi-annually: once in October and once in April.</p>
<b>Exclusion Criteria</b>	Patients who do not have a diagnosis of diabetes, in any setting, during the measurement year or year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• DPP reporting</li> <li>• DSRIP reporting</li> <li>• Provider-level eligibility files</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:<sup>1</sup></p> <ul style="list-style-type: none"> <li>• Pre: 10/1/2013- 9/30/2021</li> <li>• Post: 9/1/2021- 8/31/2022<sup>2</sup></li> </ul> <p>Separated by payer source (Medicaid, other insurance, other), if feasible</p> <p>DPP characteristics (participating DPP, DPP incentive structure), where applicable</p> <p>Provider characteristics (provider type, region, etc.), where applicable</p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	No change or an increase in this measure following DPP implementation would suggest RAPPs and TIPPS promote diabetes care for Texans.
<b>Benchmark</b>	NCQA Quality Compass 2020, 50 <sup>th</sup> Percentile National Benchmark: 88.8

*Notes.* <sup>1</sup> Because DSRIP operates on DYs and DPP operate on SFYs, there will be a one-month overlap between the pre- and post-periods. <sup>2</sup> The initial preprints for the CHIRP, DPP BHS, RAPPs, and TIPPS are applicable through August 31, 2022; QIPP is approved through August 31, 2022. Should CMS approve additional years of DPP implementation, the DPP evaluation component will be expanded to include additional years of data. HbA1c=Hemoglobin A1c; HEDIS®=Healthcare Effectiveness Data and Information Set; RAPPs=Rural Access to Primary and Preventive Services; TIPPS=Texas Incentives for Physician and Professional Services;

NCQA=National Committee for Quality Assurance; DPP=Directed Payment Program;  
DSRIP=Delivery System Reform Incentive Payment; DTA=Descriptive trend analysis;  
DY=Demonstration year, October 1-September 30; SFY=State Fiscal Year, September 1-August  
31; CHIRP=Comprehensive Hospital Increase Reimbursement Program; DPP BHS=Directed  
Payment Program for Behavioral Health Services; QIPP=Quality Incentive Payment Program;  
CMS=Centers for Medicare and Medicaid Services.

## H5.2. DPPs promote effective practices for people with chronic and serious conditions.

<b>Measure 5.2.1</b>	<b>Comprehensive diabetes care: Hemoglobin A1c (HbA1c) poor control (&gt;9.0%; HEDIS®)</b>
<b>Definition</b>	The percentage of patients ages 18 to 75 with diabetes who had hemoglobin A1c >9.0%.
<b>Study Population</b>	TIPPS clients
<b>Measure Steward or Source</b>	NCQA (HEDIS®) measure: Comprehensive diabetes care (CDC)
<b>Technical Specifications</b>	<p><b>Numerator:</b> Patients whose most recent HbA1c level (performed during the measurement period) is &gt;9.0%</p> <p><b>Denominator:</b> Patients ages 18 to 75 with diabetes with a visit during the measurement period</p> <p><b>Rate:</b> (Numerator / Denominator) * 100</p> <p>Providers in TIPPS will report this measure semi-annually: once in October and once in April.</p>
<b>Exclusion Criteria</b>	<p>Patients whose hospice care overlaps the measurement period</p> <p>Patients 66 and older who are living long term in an institution for more than 90 consecutive days during the measurement period</p> <p>Patients 66 and older with advanced illness and frailty because it is unlikely that patients will benefit from the services being measured</p>
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• DPP reporting</li> <li>• DSRIP reporting</li> <li>• Provider-level eligibility files</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:<sup>1</sup></p> <ul style="list-style-type: none"> <li>• Pre: 10/1/2013- 9/30/2021</li> <li>• Post: 9/1/2021- 8/31/2022<sup>2</sup></li> </ul> <p>Separated by payer source (Medicaid, other insurance, other), if feasible</p> <p>Provider characteristics (provider type, region, etc.), where applicable</p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	No change or a decrease in this measure following DPP implementation would suggest TIPPS promotes diabetes care for Texans.

<b>Measure 5.2.1</b>	<b>Comprehensive diabetes care: Hemoglobin A1c (HbA1c) poor control (&gt;9.0%; HEDIS®)</b>
<b>Benchmark</b>	NCQA Quality Compass 2020, 25 <sup>th</sup> Percentile National Benchmark: 44.8

*Notes.* <sup>1</sup> Because DSRIP operates on DYs and DPP operate on SFYs, there will be a one-month overlap between the pre- and post-periods. <sup>2</sup> The initial preprints for the CHIRP, DPP BHS, RAPPS, and TIPPS are applicable through August 31, 2022; QIPP is approved through August 31, 2022. Should CMS approve additional years of DPP implementation, the DPP evaluation component will be expanded to include additional years of data. HbA1c=Hemoglobin A1c; HEDIS®=Healthcare Effectiveness Data and Information Set; TIPPS=Texas Incentives for Physician and Professional Services; NCQA=National Committee for Quality Assurance; DPP=Directed Payment Program; DSRIP=Delivery System Reform Incentive Payment; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30; SFY=State Fiscal Year, September 1-August 31; CHIRP=Comprehensive Hospital Increase Reimbursement Program; DPP BHS=Directed Payment Program for Behavioral Health Services; RAPPS=Rural Access to Primary and Preventive Services; QIPP=Quality Incentive Payment Program; CMS=Centers for Medicare and Medicaid Services.

<b>Measure 5.2.2</b>	<b>Controlling high blood pressure (HEDIS®)</b>
<b>Definition</b>	The percentage of patients ages 18 to 85 who had a diagnosis of hypertension overlapping the measurement period or the year prior to the measurement period, and whose most recent blood pressure was adequately controlled (<140/90mmHg).
<b>Study Population</b>	TIPPS clients
<b>Measure Steward or Source</b>	NCQA (HEDIS®) measure: Controlling high blood pressure (CBP)
<b>Technical Specifications</b>	<p><b>Numerator:</b> Patients whose most recent blood pressure is adequately controlled (systolic blood pressure &lt;140 mmHg and diastolic blood pressure &lt;90 mmHg) during the measurement period</p> <p><b>Denominator:</b> Patients ages 18 to 85 who had a visit and diagnosis of essential hypertension overlapping the measurement period or the year prior to the measurement period</p> <p><b>Rate:</b> (Numerator / Denominator) * 100</p> <p>Providers in TIPPS will report this measure semi-annually: once in October and once in April.</p>

<b>Measure 5.2.2</b>	<b>Controlling high blood pressure (HEDIS®)</b>
<b>Exclusion Criteria</b>	<p>Patients with evidence of end stage renal disease, dialysis, or renal transplant before or during the measurement period</p> <p>Patients with a diagnosis of pregnancy during the measurement period</p> <p>Patients whose hospice care overlaps the measurement period</p> <p>Patients 66 and older who are living long term in an institution for more than 90 consecutive days during the measurement period</p> <p>Patients 66 and older with advanced illness and frailty because it is unlikely that patients will benefit from the services being measured</p>
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• DPP reporting</li> <li>• DSRIP reporting</li> <li>• Provider-level eligibility files</li> </ul>
<b>Comparison Group(s)/Subgroup(s)</b>	<p>Pre-post comparison:<sup>1</sup></p> <ul style="list-style-type: none"> <li>• Pre: 10/1/2013- 9/30/2021</li> <li>• Post: 9/1/2021- 8/31/2022<sup>2</sup></li> </ul> <p>Separated by payer source (Medicaid, other insurance, other), if feasible</p> <p>Provider characteristics (provider type, region, etc.), where applicable</p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	No change or an increase in this measure following DPP implementation would suggest TIPPS promotes hypertension care for Texans.
<b>Benchmark</b>	NCQA Quality Compass 2020, 50 <sup>th</sup> Percentile National Benchmark: 61.8

*Notes.* <sup>1</sup> Because DSRIP operates on DYs and DPP operate on SFYs, there will be a one-month overlap between the pre- and post-periods. <sup>2</sup> The initial preprints for the CHIRP, DPP BHS, RAPPs, and TIPPS are applicable through August 31, 2022; QIPP is approved through August 31, 2022. Should CMS approve additional years of DPP implementation, the DPP evaluation component will be expanded to include additional years of data. HEDIS®=Healthcare Effectiveness Data and Information Set; TIPPS=Texas Incentives for Physician and Professional Services; NCQA=National Committee for Quality Assurance; DPP=Directed Payment Program; DSRIP=Delivery System Reform Incentive Payment; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30; SFY=State Fiscal Year, September 1-August 31; CHIRP=Comprehensive Hospital Increase Reimbursement Program; DPP BHS=Directed Payment Program for Behavioral Health Services; RAPPs=Rural Access to Primary and Preventive



Services; QIPP=Quality Incentive Payment Program; CMS=Centers for Medicare and Medicaid Services.

<b>Measure 5.2.3</b>	<b>Percentage of nursing facility residents who received an antipsychotic medication</b>
<b>Definition</b>	The percentage of long-stay nursing facility residents who are receiving antipsychotic drugs.
<b>Study Population</b>	QIPP residents
<b>Measure Steward or Source</b>	CMS
<b>Technical Specifications</b>	<p><b>Numerator:</b> Long-stay nursing facility residents with a selected target assessment where the following condition is true: Antipsychotic medications received during the measurement period</p> <p><b>Denominator:</b> Long-stay nursing facility residents with a selected target assessment during the measurement period</p> <p><b>Rate:</b> (Numerator / Denominator) * 100</p>
<b>Exclusion Criteria</b>	<p>Any of the following related conditions are present on the target assessment:</p> <ul style="list-style-type: none"> <li>• Schizophrenia</li> <li>• Tourette's syndrome</li> <li>• Tourette's syndrome on the prior assessment if this item is not active on the target assessment and if a prior assessment is not available</li> <li>• Huntington's disease</li> </ul>
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• Long-stay MDS data</li> <li>• Provider-level eligibility files</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	Provider characteristics (provider type, region, etc.), where applicable
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	No change or a decrease in this measure over time would suggest that QIPP promotes non-pharmaceutical approaches to treatment for individuals residing in nursing facilities.
<b>Benchmark</b>	None

Notes. QIPP=Quality Incentive Payment Program; CMS=Centers for Medicare and Medicaid Services; MDS=Minimum Data Set; DTA=Descriptive trend analysis.

<b>Measure 5.2.4</b>	<b>Follow-up after hospitalization for mental illness (7-day and 30-day; HEDIS®)</b>
<b>Definition</b>	The percentage of discharges for patients, 6 years of age and older, who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with 7- or 30-days of discharge.
<b>Study Population</b>	DPP BHS clients
<b>Measure Steward or Source</b>	National Committee for Quality Assurance (NCQA; HEDIS®): Follow-up after hospitalization for mental illness (FUH)
<b>Technical Specifications</b>	<p><b>7-Day Numerator:</b> A follow-up visit with a mental health provider within 7 days after acute inpatient discharge</p> <p><b>30-Day Numerator:</b> A follow-up visit with a mental health provider within 30 days after acute inpatient discharge</p> <p><b>Denominator:</b> Patients 6 years of age and older who were discharged from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness or intentional self-harm in measurement period</p> <p><b>7-Day Rate:</b> (7-day Numerator / Denominator) * 100</p> <p><b>30-Day Rate:</b> (3-day Numerator / Denominator) * 100</p> <p>Providers in DPP BHS will report this measure semi-annually: once in October and once in April.</p>
<b>Exclusion Criteria</b>	<p>Discharges followed by readmission or direct transfer to a non-acute facility within the 7- or 30-day follow-up period, regardless of principal diagnosis for the readmission, or to an acute facility within the 7- or 30-day follow-up period if the principal diagnosis was for non-mental health</p> <p>Clinician-documented reason patient was not able to complete 7- or 30-day follow-up from acute inpatient setting discharge (i.e., patient death prior to follow-up visit, patient non-compliance for follow-up)</p> <p>Patients who use hospice services any time during the measurement period</p> <p>Follow-up visits that occur on the date of discharge</p>
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• DPP reporting</li> <li>• DSRIP reporting</li> <li>• Provider-level eligibility files</li> </ul>

<b>Measure 5.2.4</b>	<b>Follow-up after hospitalization for mental illness (7-day and 30-day; HEDIS®)</b>
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:<sup>1</sup></p> <ul style="list-style-type: none"> <li>• Pre: 10/1/2013- 9/30/2021</li> <li>• Post: 9/1/2021- 8/31/2022<sup>2</sup></li> </ul> <p>Separated by payer source (Medicaid, other insurance, other), if feasible</p> <p>Provider characteristics (provider type, region, etc.), where applicable</p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	No changes or increases in the rates under this measure following DPP implementation would suggest DPP BHS promotes mental health care for Texans.
<b>Benchmark</b>	<p>NCQA Quality Compass 2020, 50<sup>th</sup> Percentile Benchmark:</p> <ul style="list-style-type: none"> <li>• 7-Day Rate: 36.8</li> <li>• 30-Day Rate: 59.4</li> </ul>

*Notes.* <sup>1</sup> Because DSRIP operates on DYs and DPP operate on SFYs, there will be a one-month overlap between the pre- and post-periods. <sup>2</sup> The initial preprints for the CHIRP, DPP BHS, RAPPS, and TIPPS are applicable through August 31, 2022; QIPP is approved through August 31, 2022. Should CMS approve additional years of DPP implementation, the DPP evaluation component will be expanded to include additional years of data. HEDIS®=Healthcare Effectiveness Data and Information Set; DPP BHS=Directed Payment Program for Behavioral Health Services; NCQA=National Committee for Quality Assurance; DPP=Directed Payment Program; DSRIP=Delivery System Reform Incentive Payment; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30; SFY=State Fiscal Year, September 1-August 31; CHIRP=Comprehensive Hospital Increase Reimbursement Program; RAPPS=Rural Access to Primary and Preventive Services; TIPPS=Texas Incentives for Physician and Professional Services; QIPP=Quality Incentive Payment Program; CMS=Centers for Medicare and Medicaid Services.

### **H5.3. DPPs promote a safer delivery system that keeps patients free from harm.**

<b>Measure 5.3.1</b>	<b>Catheter-associated urinary tract infections</b>
<b>Definition</b>	The percentage of healthcare-associated catheter-associated urinary tract infections (CAUTIs) among patients in bedded inpatient care locations.
<b>Study Population</b>	CHIRP clients
<b>Measure Steward or Source</b>	CDC

<b>Measure 5.3.1</b>	<b>Catheter-associated urinary tract infections</b>
<b>Technical Specifications</b>	<p><b>Numerator:</b> Total number of observed healthcare-associated CAUTI among patients in bedded inpatient care locations</p> <p><b>Denominator:</b> Total number of predicted healthcare-associated CAUTI among inpatient care locations under surveillance for CAUTI during the measurement period, based on the national CAUTI baseline. Denominator value is calculated using the facility's number of catheter days and the following significant risk factors:</p> <ul style="list-style-type: none"> <li>• Acute Care Hospitals: CDC location, facility bed size, medical school affiliation, and facility type</li> <li>• Critical Access Hospitals: medical school affiliation</li> <li>• Long-Term Acute Hospitals: average length of stay, setting type, and location type</li> <li>• Inpatient Rehabilitation Facilities: setting type, proportion of admissions with traumatic and non-traumatic spinal cord dysfunction, and proportion of admissions with stroke</li> </ul> <p><b>Rate:</b> (Numerator / Denominator) * 100</p> <p>Providers in CHIRP will report this rate as two separate measures based on hospital type:</p> <ul style="list-style-type: none"> <li>• CAUTI: State-owned hospitals that are not IMDs and urban hospitals</li> <li>• Pediatric CAUTI: Children's hospitals</li> </ul> <p>Providers in CHIRP will report this measure semi-annually: once in October and once in April.</p>
<b>Exclusion Criteria</b>	Patients in Level II or III neonatal ICUs
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• DPP reporting</li> <li>• DSRIP reporting</li> <li>• Provider-level eligibility files</li> </ul>
<b>Comparison Group(s)/Subgroup(s)</b>	<p>Pre-post comparison:<sup>1</sup></p> <ul style="list-style-type: none"> <li>• Pre: 10/1/2013- 9/30/2021</li> <li>• Post: 9/1/2021- 8/31/2022<sup>2</sup></li> </ul> <p>Separated by payer source (Medicaid, other insurance, other), if feasible</p> <p>Provider characteristics (provider type, region, etc.), where applicable</p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	No change or a decrease in this measure following DPP implementation would suggest CHIRP promotes a safe delivery system for Texans.

<b>Measure 5.3.1</b>	<b>Catheter-associated urinary tract infections</b>
<b>Benchmark</b>	None

*Notes.* <sup>1</sup> Because DSRIP operates on DYs and DPP operate on SFYs, there will be a one-month overlap between the pre- and post-periods. <sup>2</sup> The initial preprints for the CHIRP, DPP BHS, RAPPs, and TIPPS are applicable through August 31, 2022; QIPP is approved through August 31, 2022. Should CMS approve additional years of DPP implementation, the DPP evaluation component will be expanded to include additional years of data. CAUTI=Catheter-Associated Urinary Tract Infection; CHIRP=Comprehensive Hospital Increased Rate Program; CDC=Centers for Disease Control and Prevention; ICU=Intensive Care Unit; DPP=Directed Payment Program; DSRIP=Delivery System Reform Incentive Payment; ACIA= Average Commercial Incentive Award; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30; SFY=State Fiscal Year, September 1-August 31; DPP BHS=Directed Payment Program for Behavioral Health Services; RAPPs=Rural Access to Primary and Preventive Services; TIPPS=Texas Incentives for Physician and Professional Services; QIPP=Quality Incentive Payment Program; CMS=Centers for Medicare and Medicaid Services.

<b>Measure 5.3.2</b>	<b>Central line-associated bloodstream infections</b>
<b>Definition</b>	The percentage of patients with healthcare-associated central line-associated bloodstream infections (CLABSIs).
<b>Study Population</b>	CHIRP clients
<b>Measure Steward or Source</b>	CDC

Measure 5.3.2	Central line-associated bloodstream infections
<b>Technical Specifications</b>	<p><b>Numerator:</b> Total number of observed healthcare-associated CLABSIs among patients in bedded inpatient care locations</p> <p><b>Denominator:</b> Total number of predicted healthcare-associated CLABSI among patients in bedded inpatient care locations, calculated using the facility's number of central line days and the following significant risk factors:</p> <ul style="list-style-type: none"> <li>• Acute Care Hospitals: CDC location, facility bed size, medical school affiliation, facility type, and birthweight category (NICU locations only)</li> <li>• Critical Access Hospitals: no significant risk factors, calculation-based intercept only model</li> <li>• Long-Term Acute Hospitals: CDC location type, facility bed size, average length of stay, proportion of admissions on a ventilator, and proportion of admissions on hemodialysis</li> <li>• Inpatient Rehabilitation Facilities: proportion of admissions with stroke and proportion of admissions in other non-specific diagnostic categories</li> </ul> <p><b>Rate:</b> (Numerator / Denominator) * 100</p> <p>Providers in CHIRP will report this rate as two separate measures based on hospital type:</p> <ul style="list-style-type: none"> <li>• CLABSI: State-owned hospitals that are not IMDs and urban hospitals</li> <li>• Pediatric CLABSI: Children's hospitals</li> </ul> <p>Providers in CHIRP will report this measure semi-annually: once in October and once in April.</p>
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• DPP reporting</li> <li>• DSRIP reporting</li> <li>• Provider-level eligibility files</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:<sup>1</sup></p> <ul style="list-style-type: none"> <li>• Pre: 10/1/2013- 9/30/2021</li> <li>• Post: 9/1/2021- 8/31/2022<sup>2</sup></li> </ul> <p>Separated by payer source (Medicaid, other insurance, other), if feasible</p> <p>Provider characteristics (provider type, region, etc.), where applicable</p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>

<b>Measure 5.3.2</b>	<b>Central line-associated bloodstream infections</b>
Interpretation	No change or a decrease in this measure following DPP implementation would suggest CHIRP promotes a safe delivery system for Texans.
Benchmark	None

*Notes.* <sup>1</sup> Because DSRIP operates on DYs and DPP operate on SFYs, there will be a one-month overlap between the pre- and post-periods. <sup>2</sup> The initial preprints for the CHIRP, DPP BHS, RAPPS, and TIPPS are applicable through August 31, 2022; QIPP is approved through August 31, 2022. Should CMS approve additional years of DPP implementation, the DPP evaluation component will be expanded to include additional years of data. CLABSI=Central Line Associated Bloodstream Infection; CHIRP=Comprehensive Hospital Increased Rate Program; CDC=Centers for Disease Control and Prevention; NICU=Neonatal Intensive Care Unit; DPP=Directed Payment Program; DSRIP=Delivery System Reform Incentive Payment; ACIA= Average Commercial Incentive Award; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30; SFY=State Fiscal Year, September 1-August 31; DPP BHS=Directed Payment Program for Behavioral Health Services; RAPPS=Rural Access to Primary and Preventive Services; TIPPS=Texas Incentives for Physician and Professional Services; QIPP=Quality Incentive Payment Program; CMS=Centers for Medicare and Medicaid Services.

<b>Measure 5.3.3</b>	<b>Percentage of nursing facility residents whose ability to move independently has worsened</b>
<b>Definition</b>	The percentage of long-stay nursing facility residents who experienced a decline in independence of locomotion.
<b>Study Population</b>	QIPP residents
<b>Measure Steward or Source</b>	CMS
<b>Technical Specifications</b>	<p><b>Numerator:</b> Long-stay nursing facility residents with a selected target assessment and at least one qualifying prior assessment who have a decline in locomotion when comparing their target assessment with the prior assessment during the measurement period</p> <p><b>Denominator:</b> Long-stay nursing facility residents who have a qualifying MDS 3.0 target assessment and at least one qualifying prior assessment during the measurement period</p> <p><b>Rate:</b> (Numerator / Denominator) * 100</p>

<b>Measure 5.3.3</b>	<b>Percentage of nursing facility residents whose ability to move independently has worsened</b>
<b>Exclusion Criteria</b>	<p>Nursing facility residents satisfying any of the following conditions:</p> <ul style="list-style-type: none"> <li>• Comatose or missing data on comatose at the prior assessment</li> <li>• Prognosis of less than 6 months at the prior assessment</li> <li>• Resident totally dependent during locomotion on prior assessment</li> <li>• Missing data on locomotion on target or prior assessment</li> <li>• Prior assessment is a discharge with or without return anticipated</li> <li>• No prior assessment is available to assess prior function</li> <li>• Target assessment is an Omnibus Budget Reconciliation Act Admission assessment or a Prospective Payment System 5-Day assessment or the first assessment after an admission</li> </ul>
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• Long-stay MDS data</li> <li>• Provider-level eligibility files</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	Provider characteristics (provider type, region, etc.), where applicable
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	No change or a decrease in this measure over time would suggest that QIPP promotes the ability to move independently among individuals residing in nursing facilities.
<b>Benchmark</b>	None

Notes. QIPP=Quality Incentive Payment Program; CMS=Centers for Medicare and Medicaid Services; MDS=Minimum Data Set; DTA=Descriptive trend analysis.

<b>Measure 5.3.4</b>	<b>Percentage of nursing facility residents with a urinary tract infection</b>
<b>Definition</b>	The percentage of long-stay nursing facility residents who have a urinary tract infection.
<b>Study Population</b>	QIPP residents
<b>Measure Steward or Source</b>	CMS



<b>Measure 5.3.4</b>	<b>Percentage of nursing facility residents with a urinary tract infection</b>
<b>Technical Specifications</b>	<p><b>Numerator:</b> Long-stay nursing facility residents with a selected target assessment that indicates urinary tract infection within the last 30 days</p> <p><b>Denominator:</b> All long-stay nursing facility residents with a selected target assessment</p> <p><b>Rate:</b> (Numerator / Denominator) * 100</p>
<b>Exclusion Criteria</b>	<p>Target assessment is an admission assessment or a Prospective Payment System 5-Day assessment</p> <p>Urinary tract infection value is missing</p>
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>Long-stay MDS data</li> <li>Provider-level eligibility tables</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	Provider characteristics (provider type, region, etc.), where applicable
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> </ul>
<b>Interpretation</b>	No change or a decrease in this measure over time would suggest QIPP promotes a safe delivery system for individuals residing in nursing facilities.
<b>Benchmark</b>	None

Notes. QIPP=Quality Incentive Payment Program; CMS=Centers for Medicare and Medicaid Services; MDS=Minimum Data Set; DTA=Descriptive trend analysis.

<b>Measure 5.3.5</b>	<b>Percentage of high-risk nursing facility residents with pressure ulcers, including unstageable ulcers</b>
<b>Definition</b>	The percentage of long-stay, high-risk nursing facility residents with Stage II-IV or unstageable pressure ulcers.
<b>Study Population</b>	QIPP residents
<b>Measure Steward or Source</b>	CMS
<b>Technical Specifications</b>	<p><b>Numerator:</b> All long-stay nursing facility residents with a selected target assessment that meet the following condition: Stage II-IV or unstageable pressure ulcers are present</p> <p><b>Denominator:</b> All long-stay nursing facility residents with a selected target assessment who meet the definition of high-risk. Residents are defined as high-risk if they meet one or more of the following three criteria on the target assessment:</p> <ol style="list-style-type: none"> <li>1. Impaired bed mobility or transfer indicated</li> <li>2. Comatose</li> <li>3. Malnutrition or at risk of malnutrition</li> </ol> <p><b>Rate:</b> (Numerator / Denominator) * 100</p>

<b>Measure 5.3.5</b>	<b>Percentage of high-risk nursing facility residents with pressure ulcers, including unstageable ulcers</b>
<b>Exclusion Criteria</b>	Target assessment is an Omnibus Budget Reconciliation Act Admission assessment or a Prospective Payment System 5-Day assessment
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>Long-stay MDS data</li> <li>Provider-level eligibility tables</li> </ul>
<b>Comparison Group(s)/Subgroup(s)</b>	Provider characteristics (provider type, region, etc.), where applicable
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> </ul>
<b>Interpretation</b>	No change or a decrease in this measure over time would suggest QIPP promotes a safe delivery system for individuals residing in nursing facilities.
<b>Benchmark</b>	None

Notes. QIPP=Quality Incentive Payment Program; CMS=Centers for Medicare and Medicaid Services; MDS=Minimum Data Set; DTA=Descriptive trend analysis.

## SPP Component

### Evaluation Question 6: Do the SPPs financially support providers serving the Medicaid and uninsured populations?

#### H6.1. The UC and PHP-CCP programs financially support Medicaid providers by reimbursing Medicaid or charity care costs in Texas.

<b>Measure 6.1.1</b>	<b>Number of UC program providers</b>
<b>Definition</b>	The unique count of providers participating in the UC program.
<b>Study Population</b>	UC program providers
<b>Measure Steward or Source</b>	N/A
<b>Technical Specifications</b>	Unique TPI count of UC providers who submitted DSH/UC application in DY
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>American Community Survey</li> <li>DSH/UC application</li> <li>Provider-level eligibility files</li> </ul>
<b>Comparison Group(s)/Subgroup(s)</b>	Provider characteristics (provider type, etc.), where applicable Regional characteristics (RUCC, uninsured rates, etc.), where applicable

<b>Measure 6.1.1</b>	<b>Number of UC program providers</b>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA, including DY1-8 data, where applicable</li> </ul>
<b>Interpretation</b>	This measure is a direct indicator of Medicaid providers that are financially supported by the UC program.
<b>Benchmark</b>	None

*Notes.* UC=Uncompensated Care; TPI=Texas provider identifier; DSH=Disproportionate Share Hospital; DY=Demonstration year, October 1-September 30; RUCC=Rural-Urban Continuum Codes; DTA=Descriptive trend analysis.

<b>Measure 6.1.2</b>	<b>Number of PHP-CCP program providers</b>
<b>Definition</b>	The unique count of providers participating in the PHP-CCP program.
<b>Study Population</b>	PHP-CCP program providers
<b>Measure Steward or Source</b>	N/A
<b>Technical Specifications</b>	Unique TPI count of PHP-CCP providers who submitted PHP-CCP application in DY
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• American Community Survey</li> <li>• PHP-CCP application</li> <li>• Provider-level eligibility files</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	Provider characteristics (provider type, etc.), where applicable Regional characteristics (RUCC, uninsured rates, etc.), where applicable
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	This measure is a direct indicator of Medicaid providers that are financially supported by the PHP-CCP program.
<b>Benchmark</b>	None

*Notes.* PHP-CCP=Public Health Provider-Charity Care Pool; TPI=Texas provider identifier; DY=Demonstration year, October 1-September 30; RUCC=Rural-Urban Continuum Codes; DTA=Descriptive trend analysis.

<b>Measure 6.1.3</b>	<b>UC costs and reimbursements</b>
<b>Definition</b>	Total costs and reimbursements for costs associated with services provided under a provider's charity care policy.
<b>Study Population</b>	UC program providers
<b>Measure Steward or Source</b>	N/A

<b>Measure 6.1.3</b>	<b>UC costs and reimbursements</b>
<b>Technical Specifications</b>	Total amount of UC eligible charity care costs, after final payments and recoupment, in DY  Total amount of UC eligible charity care costs reimbursed, after final payments and recoupment, in DY.
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>American Community Survey</li> <li>DSH/UC application</li> <li>Provider-level eligibility files</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	Provider characteristics (provider type, etc.), where applicable Regional characteristics (RUCC, uninsured rates, etc.), where applicable
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> </ul>
<b>Interpretation</b>	This measure is a direct indicator of financial support delivered through the UC program to Medicaid providers.
<b>Benchmark</b>	None

*Notes.* UC=Uncompensated Care; DY=Demonstration year, October 1-September 30; DSH=Disproportionate Share Hospital; RUCC=Rural-Urban Continuum Codes; DTA=Descriptive trend analysis.

<b>Measure 6.1.4</b>	<b>PHP-CCP costs and reimbursements</b>
<b>Definition</b>	Total costs and reimbursements for costs associated used to defray actual uncompensated care (DY11), or costs associated with services provided under a provider's charity care policy (DY 12 forward).
<b>Study Population</b>	PHP-CCP program providers
<b>Measure Steward or Source</b>	N/A
<b>Technical Specifications</b>	Total amount of PHP-CCP eligible costs, after final payments and recoupment, in DY  Total amount of PHP-CCP eligible costs reimbursed, after final payments and recoupment, in DY.
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>American Community Survey</li> <li>PHP-CCP application</li> <li>Provider-level eligibility files</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	Provider characteristics (provider type, etc.), where applicable Regional characteristics (RUCC, uninsured rates, etc.), where applicable

<b>Measure 6.1.4</b>	<b>PHP-CCP costs and reimbursements</b>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	This measure is a direct indicator of financial support delivered through the PHP-CCP program to Medicaid providers.
<b>Benchmark</b>	None

*Notes.* PHP-CCP=Public Health Provider-Charity Care Pool; DY=Demonstration year, October 1-September 30; RUCC=Rural-Urban Continuum Codes; DTA=Descriptive trend analysis.

<b>Measure 6.1.5</b>	<b>Perceived successes and challenges of SPPs</b>
<b>Definition</b>	Perceived success and challenges of SPPs in supporting: <ul style="list-style-type: none"> <li>• Provider operations</li> <li>• Provider sustainability</li> </ul>
<b>Study Population</b>	UC program providers; PHP-CCP program providers
<b>Measure Steward or Source</b>	N/A – External evaluator will develop survey
<b>Technical Specifications</b>	UC and PHP-CCP program providers will be asked to provide feedback on the successes and challenges of SPPs in supporting Medicaid provider operations and provider sustainability.
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• Provider Survey (to be developed by external evaluator)</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	Respondent characteristics (provider type, region, etc.), where applicable
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Thematic content analysis</li> </ul>
<b>Interpretation</b>	Respondent perspectives will provide direct insight into successes and challenges of SPPs in supporting Medicaid providers in Texas.
<b>Benchmark</b>	None

*Notes.* SPP=Supplemental Payment Program; UC=Uncompensated Care; PHP-CCP=Public Health Provider-Charity Care Pool.

<b>Measure 6.1.6</b>	<b>Provider perspectives on state priorities and policy development</b>
<b>Definition</b>	Provider perspectives on and recommendations for state priorities and policy development related to supporting Medicaid providers.
<b>Study Population</b>	UC program providers; PHP-CCP program providers
<b>Measure Steward or Source</b>	N/A – External evaluator will develop survey

<b>Measure 6.1.6</b>	<b>Provider perspectives on state priorities and policy development</b>
<b>Technical Specifications</b>	UC and PHP-CCP program providers will be asked to share perspectives on and recommendations for state priorities and policy development related to supporting Medicaid providers in Texas.
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>Provider Survey (to be developed by external evaluator)</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	Respondent characteristics (provider type, region, etc.), where applicable
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>Thematic content analysis</li> </ul>
<b>Interpretation</b>	Respondent perspectives will provide direct insight into provider considerations for state programs that support Medicaid providers in Texas.
<b>Benchmark</b>	None

Notes. UC=Uncompensated Care; PHP-CCP=Public Health Provider-Charity Care Pool.

### **Evaluation Question 7: Did the implementation of UHRIP support the hospital delivery system during the transition of the UC program to charity care only?**

#### **H7.1. Hospital-based performance measures will maintain or improve following the transition to charity care only in DY9.**

<b>Measure 7.1.1</b>	<b>Average length of stay per Medicaid inpatient hospital admission</b>
<b>Definition</b>	The average number of days of care per Medicaid inpatient hospital admission.
<b>Study Population</b>	Medicaid clients served by UC program providers in UHRIP
<b>Measure Steward or Source</b>	N/A
<b>Technical Specifications</b>	<p><b>Numerator:</b> Total number of days across all Medicaid inpatient hospital admissions</p> <p><b>Denominator:</b> Unique count of Medicaid inpatient hospital admissions</p> <p><b>Rate:</b> Numerator / Denominator</p> <p>The rate can be calculated per quarter or DY.</p>
<b>Exclusion Criteria</b>	UC program providers not participating in UHRIP (non-hospital providers: ambulance providers, dental providers, and physician group practices)

<b>Measure 7.1.1</b>	<b>Average length of stay per Medicaid inpatient hospital admission</b>
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• DSH/UC application</li> <li>• FFS Claims and MMC Encounters</li> <li>• Member-level enrollment files</li> <li>• Provider-level eligibility files</li> <li>• UHRIP administrative data</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:<sup>1</sup></p> <ul style="list-style-type: none"> <li>• Pre: 10/1/2011- 9/30/2019</li> <li>• Post: 10/1/2019- 9/30/2030</li> </ul> <p>Member characteristics (age, race/ethnicity, MMC program, region, etc.), where applicable</p> <p>Provider characteristics (provider type, region, etc.), where applicable</p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• ITS</li> </ul>
<b>Interpretation</b>	No change or a decrease in this measure after DY9 would suggest UHRIP helped to maintain or improve hospital-based performance following the transition of the UC program to charity care only.
<b>Benchmark</b>	None

*Notes.* <sup>1</sup> Contingent of CMS approval, UHRIP will transition to a component of CHIRP on September 1, 2021. The external evaluator may utilize multiple pre- or post-periods to capture implementation changes related to UHRIP and the transition to CHIRP, if feasible.

UC=Uncompensated Care; UHRIP=Uniform Hospital Rate Increase Program; DY=Demonstration year, October 1-September 30; DSH=Disproportionate Share Hospital; FFS=Fee-for-service; MMC=Medicaid managed care; ITS=Interrupted time series.

<b>Measure 7.1.2</b>	<b>Average cost per Medicaid inpatient hospital admission</b>
<b>Definition</b>	The average cost per Medicaid inpatient hospital admission.
<b>Study Population</b>	Medicaid clients served by UC program providers in UHRIP
<b>Measure Steward or Source</b>	N/A
<b>Technical Specifications</b>	<p><b>Numerator:</b> Total cost across all Medicaid inpatient hospital admissions</p> <p><b>Denominator:</b> Unique count of Medicaid inpatient hospital admissions</p> <p><b>Rate:</b> Numerator / Denominator</p> <p>The rate can be calculated per quarter or DY.</p>
<b>Exclusion Criteria</b>	UC program providers not participating in UHRIP (non-hospital providers: ambulance providers, dental providers, and physician group practices)

<b>Measure 7.1.2</b>	<b>Average cost per Medicaid inpatient hospital admission</b>
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• DSH/UC application</li> <li>• FFS Claims and MMC Encounters</li> <li>• Member-level enrollment files</li> <li>• Provider-level eligibility fil</li> <li>• UHRIP administrative data</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:<sup>1</sup></p> <ul style="list-style-type: none"> <li>• Pre: 10/1/2011- 9/30/2019</li> <li>• Post: 10/1/2019- 9/30/2030</li> </ul> <p>Member characteristics (age, race/ethnicity, MMC program, region, etc.), where applicable</p> <p>Provider characteristics (provider type, region, etc.), where applicable</p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• ITS</li> </ul>
<b>Interpretation</b>	No change or a decrease in this measure after DY9 would suggest UHRIP helped to maintain or improve hospital-based performance following the transition of the UC program to charity care only.
<b>Benchmark</b>	None

*Notes.* <sup>1</sup> Contingent of CMS approval, UHRIP will transition to a component of CHIRP on September 1, 2021. The external evaluator may utilize multiple pre- or post-periods to capture implementation changes related to UHRIP and the transition to CHIRP, if feasible.  
UC=Uncompensated Care; UHRIP=Uniform Hospital Rate Increase Program; DY=Demonstration year, October 1-September 30; DSH=Disproportionate Share Hospital; FFS=Fee-for-service; MMC=Medicaid managed care; ITS=Interrupted time series.

<b>Measure 7.1.3</b>	<b>Patients' perceptions of hospital care</b>
<b>Definition</b>	Patients' experience with hospital care during a recent inpatient hospital stay.
<b>Study Population</b>	Patients served by UC program providers in UHRIP



<b>Measure 7.1.3</b>	<b>Patients' perceptions of hospital care</b>
<b>Measure Steward or Source</b>	<p>Agency for Healthcare Research and Quality (AHRQ), administered by CMS</p> <p>State-level HCAHPS® results are publicly accessible via:</p> <ul style="list-style-type: none"> <li>• Patient survey (HCAHPS®) - State: <a href="https://data.cms.gov/provider-data/dataset/84jm-wiui">https://data.cms.gov/provider-data/dataset/84jm-wiui</a></li> <li>• HCAHPS® Hospital Survey Website: <a href="https://hcahpsonline.org/en/summary-analyses/previous-summary-analyses-documents/">https://hcahpsonline.org/en/summary-analyses/previous-summary-analyses-documents/</a></li> </ul> <p>Provider-level HCAHPS® results are publicly available via:</p> <ul style="list-style-type: none"> <li>• Hospital comparison website: <a href="https://www.medicare.gov/care-compare/?providerType=Hospital&amp;redirect=true#search">https://www.medicare.gov/care-compare/?providerType=Hospital&amp;redirect=true#search</a></li> </ul>
<b>Technical Specifications</b>	<p>CMS administers the HCAHPS® survey to a random sample of adult patients who have been recently discharged. The HCAHPS® survey assesses patients' experience of communicating with nurses and doctors, patients' perception of hospital staff responsiveness, communication about medicines, hospital quietness and cleanliness, information about discharge, post-hospital care transition planning, and rating the hospital overall.</p> <p>HCAHPS® survey results are presented per CY.</p>
<b>Exclusion Criteria</b>	UC program providers not participating in UHRIP (non-hospital providers: ambulance providers, dental providers, and physician group practices)
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• CMS HCAHPS® Surveys</li> <li>• DSH/UC application</li> <li>• Provider-level eligibility files</li> <li>• UHRIP administrative data</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:<sup>1,2</sup></p> <ul style="list-style-type: none"> <li>• Pre: 1/1/2012- 12/31/2019<sup>3</sup></li> <li>• Post: 1/1/2020- 12/31/2029<sup>4</sup></li> </ul> <p>Provider characteristics (provider type, region, etc.), where applicable</p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> <li>• ITS, if feasible</li> </ul>
<b>Interpretation</b>	No change or an increase in this measure after DY9 would suggest UHRIP helped to maintain or improve hospital-based performance following the transition of the UC program to charity care only.

<b>Measure 7.1.3</b>	<b>Patients' perceptions of hospital care</b>
<b>Benchmark</b>	<p>HCAHPS® Percentile Tables 2018 Discharges, National Average "Top Box" Score:<sup>5</sup></p> <ul style="list-style-type: none"> <li>• Communication with nurses: 81.0</li> <li>• Communication with doctors: 81.0</li> <li>• Responsiveness of hospital staff: 70.0</li> <li>• Communication about medicines: 66.0</li> <li>• Cleanliness of hospital environment: 75.0</li> <li>• Quietness of hospital environment: 62.0</li> <li>• Discharge information: 87.0</li> <li>• Care transition: 53.0</li> <li>• Hospital rating: 73.0</li> <li>• Would recommend hospital: 72.0</li> </ul>

*Notes.* <sup>1</sup> Provider-level HCAHPS® survey results may not be available for the entire the pre- and post-periods. The external evaluator may use the all provider-level data available or may choose to use state-level estimates. <sup>2</sup> Contingent of CMS approval, UHRIP will transition to a component of CHIRP on September 1, 2021. The external evaluator may utilize multiple pre- or post-periods to capture implementation changes related to UHRIP and the transition to CHIRP, if feasible. <sup>3</sup> HCAHPS® survey results are published for calendar years (January 1 – December 31). As a result, pre- and post-periods for do not align with DYs. <sup>4</sup> The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. The external evaluator may extend the post-period if additional data become available prior to the Summative evaluation report. <sup>5</sup> "Top Box" scores reflect how often respondents provided positive assessments of the hospital experience. HCAHPS® Percentile Tables are accessible via: <https://hcahpsonline.org/en/summary-analyses/previous-summary-analyses-documents/>. UC=Uncompensated Care; UHRIP=Uniform Hospital Rate Increase Program; AHRQ=Agency for Healthcare Research and Quality; CMS=Centers for Medicare and Medicaid Services; HCAHPS®=Hospital Consumer Assessment of Healthcare Providers and Systems; CY=Calendar year, January 1-December 31; DSH=Disproportionate Share Hospital; DTA=Descriptive trend analysis; ITS=Interrupted time series; DY=Demonstration year, October 1-September 30.

<b>Measure 7.1.4</b>	<b>Potentially preventable complications (3M)</b>
<b>Definition</b>	A harmful event or negative outcome, such as an infection or surgical complication, that occurs during a hospital admission or a long-term care facility stay, which was not present on admission and might have resulted from poor care or treatment rather than from natural progression of the underlying disease.
<b>Study Population</b>	UC program providers in UHRIP
<b>Measure Steward or Source</b>	EQRO-calculated measures using 3M software

<b>Measure 7.1.4</b>	<b>Potentially preventable complications (3M)</b>
<b>Technical Specifications</b>	<p>Following the 3M protocol, the EQRO identifies inpatient admissions at-risk for being a potentially preventable complication (PPC), actual PPCs, assigns weights, risk-adjusts PPCs, and calculates expected-to-actual PPC rates.</p> <p>As of CY 2019, the EQRO published the following information on PPCs:</p> <ul style="list-style-type: none"> <li>• Total at-risk admissions</li> <li>• Number of admissions that had one or more PPC</li> <li>• Number of PPCs</li> <li>• Total weight of all PPCs</li> <li>• Expected weight across all PPCs</li> <li>• Actual weight divided by expected weight</li> <li>• Total PPC weight per 1,000 at-risk admissions</li> </ul>
<b>Exclusion Criteria</b>	<p>UC program providers not participating in UHRIP (non-hospital providers: ambulance providers, dental providers, and physician group practices)</p> <p>Exclusion criteria specified by 3M</p>
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• EQRO-calculated PPE performance measures</li> <li>• Provider-level eligibility files</li> <li>• UHRIP administrative data</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:<sup>1,2,3</sup></p> <ul style="list-style-type: none"> <li>• Pre: 1/1/2016- 12/31/2019</li> <li>• Post: 1/1/2020- 12/31/2029<sup>4</sup></li> </ul> <p>Provider characteristics (provider type, region, etc.), where applicable</p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	No change or a decrease in this measure after DY9 would suggest UHRIP helped to maintain or improve hospital-based performance following the transition of the UC program to charity care only.
<b>Benchmark</b>	None

*Notes.* <sup>1</sup> Due to 3M software changes, PPC rates prior to January 1, 2016 are excluded. <sup>2</sup> Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods do not align with DYs. <sup>3</sup> Contingent of CMS approval, UHRIP will transition to a component of CHIRP on September 1, 2021. The external evaluator may utilize multiple pre- or post-periods to capture implementation changes related to UHRIP and the transition to CHIRP, if feasible. <sup>4</sup> The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. The external evaluator may extend the post-period if additional data become available prior to the Summative evaluation report. UC=Uncompensated Care; UHRIP=Uniform Hospital Rate Increase Program; EQRO=Texas's External Quality Review Organization; PPC=Potentially preventable complication; CY=Calendar year, January 1-December

31; PPE=Potentially preventable event; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30.

<b>Measure 7.1.5</b>	<b>Potentially preventable readmissions (3M)</b>
<b>Definition</b>	A return hospitalization within 30 days that might have resulted from problems in care during a previous hospital stay or from deficiencies in a post-hospital discharge follow-up.
<b>Study Population</b>	UC program providers in UHRIP
<b>Measure Steward or Source</b>	EQRO-calculated measures using 3M software
<b>Technical Specifications</b>	<p>Following the 3M protocol, the EQRO identifies readmissions with a plausible clinical relationship to a prior admission, readmissions at-risk for being a potentially preventable readmission (PPR), actual PPRs, assigns weights, risk-adjusts PPRs, and calculates expected-to-actual PPR rates.</p> <p>As of CY 2019, the EQRO published the following information on PPRs:</p> <ul style="list-style-type: none"> <li>• Total at-risk admissions</li> <li>• The number of PPR chains</li> <li>• Number of PPRs</li> <li>• Total weight of all PPRs</li> <li>• Expected weight across all PPRs</li> <li>• Actual weight divided by expected weight</li> <li>• Total PPR weight per 1,000 at-risk admissions</li> <li>• Sum of the institutional expenditures across all PPRs</li> </ul>
<b>Exclusion Criteria</b>	<p>UC program providers not participating in UHRIP (non-hospital providers: ambulance providers, dental providers, and physician group practices)</p> <p>Exclusion criteria specified by 3M</p>
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• EQRO-calculated PPE performance measures</li> <li>• Provider-level eligibility files</li> <li>• UHRIP administrative data</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>Pre-post comparison:<sup>1,2,3</sup></p> <ul style="list-style-type: none"> <li>• Pre: 1/1/2012- 12/31/2019</li> <li>• Post: 1/1/2020- 12/31/2029<sup>4</sup></li> </ul> <p>Provider characteristics (provider type, region, etc.), where applicable</p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>

<b>Measure 7.1.5</b>	<b>Potentially preventable readmissions (3M)</b>
<b>Interpretation</b>	No change or a decrease in this measure after DY9 would suggest UHRIP helped to maintain or improve hospital-based performance following the transition of the UC program to charity care only.
<b>Benchmark</b>	None

*Notes.* <sup>1</sup> Due to 3M software changes, PPR rates prior to January 1, 2012 are excluded. <sup>2</sup> Starting January 1, 2010, the EQRO began calculating Texas MMC program measures each calendar year (January 1 – December 31). As a result, pre- and post-periods do not align with DYs. <sup>3</sup> Contingent of CMS approval, UHRIP will transition to a component of CHIRP on September 1, 2021. The external evaluator may utilize multiple pre- or post-periods to capture implementation changes related to UHRIP and the transition to CHIRP, if feasible. <sup>4</sup> The post-period ends on December 31, 2029, the last full calendar year before the Ten-Year Demonstration Extension approval period ends. The external evaluator may extend the post-period if additional data become available prior to the Summative evaluation report. UC=Uncompensated Care; UHRIP=Uniform Hospital Rate Increase Program; EQRO=Texas's External Quality Review Organization; PPR=Potentially preventable readmission; CY=Calendar year, January 1-December 31; PPE=Potentially preventable event; DTA=Descriptive trend analysis; DY=Demonstration year, October 1-September 30.

## Overall Demonstration Component

### Evaluation Question 8. What are the costs of providing health care services to Medicaid beneficiaries served under the Demonstration?

#### H8.1. The Demonstration results in overall savings in health care service expenditures.

<b>Measure 8.1.1</b>	<b>Actual Medicaid health service expenditures</b>
<b>Definition</b>	Actual Medicaid health care expenditures for Medicaid beneficiaries served prior to or under the Demonstration.
<b>Study Population</b>	Medicaid Eligibility Groups served under the Demonstration
<b>Measure Steward or Source</b>	N/A
<b>Technical Specifications</b>	<p>WW expenditures for MEGs served under the Demonstration per DY</p> <p>The external evaluator will calculate inflation adjustments as necessary.</p> <p>The external evaluator should present this measure alongside Measure 8.1.2 (Hypothetical WOW Medicaid health service expenditures).</p>

<b>Measure 8.1.1</b>	<b>Actual Medicaid health service expenditures</b>
<b>Exclusion Criteria</b>	Expenditures not associated with traditional reimbursement of Medicaid claims and encounters (e.g., SPPs or DPPs)
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>Budget neutrality worksheet</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>WW costs versus WOW costs</p> <p>MEGs served under the Demonstration</p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> </ul>
<b>Interpretation</b>	This measure is a direct indicator the costs of providing health care services to MMC members under the Demonstration.
<b>Benchmark</b>	None; Historical health care expenditures for Medicaid clients (FFS and MMC) prior to the Demonstration (October 2006 – September 2010) may be used as a contextual reference cohort <sup>1</sup>

*Notes.* <sup>1</sup> HHSC calculations of health care service expenditures prior to the Demonstration can be shared with the external evaluator upon request. Historical health care expenditures prior to the Demonstration include individuals receiving services through FFS and MMC. Most individuals who received services through FFS prior to the Demonstration transitioned into MMC and are included in WW expenditures for MEGs. However, at the time of writing, approximately 6% of all Medicaid beneficiaries received services through FFS, and therefore are not included in WW expenditures for MEGs. As a result, trends in historical health care expenditures are provided for contextual reference only and should not be used to make direct dollar amount comparisons. Additional information on historical expenditures prior to the Demonstration is presented in HHSC's Rider 61 Final Comprehensive Report: Evaluation of Medicaid and CHIP Managed Care, August 2018. This evaluation was conducted in partnership with Deloitte LLP and is accessible via: <https://www.hhs.texas.gov/reports/2018/08/rider-61-evaluation-medicaid-chip-managed-care>. WW=With waiver; MEG=Medicaid Eligibility Group; DY=Demonstration year, October 1-September 30; FFS=Fee-for-service; SPP=Supplemental Payment Program; DPP=Directed Payment Program; DTA=Descriptive trend analysis; MMC=Medicaid managed care.

<b>Measure 8.1.2</b>	<b>Hypothetical WOW Medicaid health service expenditures</b>
<b>Definition</b>	Hypothetical Medicaid health care service expenditures for MMC members served under the Demonstration if the Demonstration did not exist (e.g., FFS).
<b>Study Population</b>	Medicaid Eligibility Groups served under the Demonstration
<b>Measure Steward or Source</b>	N/A

<b>Measure 8.1.2</b>	<b>Hypothetical WOW Medicaid health service expenditures</b>
<b>Technical Specifications</b>	<p>WOW expenditures for MEGs served under the Demonstration per DY</p> <p>The external evaluator will calculate inflation adjustments as necessary.</p> <p>The external evaluator should present this measure alongside Measure 8.1.1 (Actual Medicaid health service expenditures).</p>
<b>Exclusion Criteria</b>	Expenditures not associated with traditional reimbursement of Medicaid claims and encounters (e.g., UPL program)
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>Budget neutrality worksheet</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	<p>WW costs versus WOW costs</p> <p>MEGs served under the Demonstration</p>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> </ul>
<b>Interpretation</b>	The difference between this measure and actual expenditure costs (Measure 8.1.1) is a direct indicator of overall cost savings in health care service expenditures.
<b>Benchmark</b>	None

*Notes.* WOW=Without waiver; MMC=Medicaid managed care; FFS=Fee-for-service; MEG=Medicaid Eligibility Group; DY=Demonstration year, October 1-September 30; UPL=Upper payment limit; DTA=Descriptive trend analysis.

## **Evaluation Question 9. What are the administrative costs of implementing and operating the Demonstration?**

### **H9.1. Administrative costs required to implement and operate the Demonstration are relatively stable and reasonable over time.**

<b>Measure 9.1.1</b>	<b>HHSC administrative costs directly attributable to the Demonstration</b>
<b>Definition</b>	HHSC-incurred administrative expenditures attributable to the Demonstration.
<b>Study Population</b>	HHSC
<b>Measure Steward or Source</b>	N/A

<b>Measure 9.1.1</b>	<b>HHSC administrative costs directly attributable to the Demonstration</b>
<b>Technical Specifications</b>	<p>Form CMS-64 includes a variety of sections detailing different types of expenditures. This measure will focus on costs attributable to the Demonstration reported on 64.10, Expenditures for State and Local Administration, per DY.</p> <p>The external evaluator will calculate inflation adjustments as necessary.</p>
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>Form CMS-64</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	Type of administrative expenditures, where applicable
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> </ul>
<b>Interpretation</b>	This measure is a director indicator of the administrative costs of implementing and operating the Demonstration.
<b>Benchmark</b>	None

*Notes.* HHSC=Health and Human Services Commission; CMS=Centers for Medicare and Medicaid Services; DY=Demonstration year, October 1-September 30; DTA=Descriptive trend analysis.

<b>Measure 9.1.2</b>	<b>MCO administrative costs</b>
<b>Definition</b>	MCO-incurred administrative expenditures for implementing MMC.
<b>Study Population</b>	MCOs
<b>Measure Steward or Source</b>	N/A
<b>Technical Specifications</b>	<p>MCO-reported administrative expenses directly or indirectly in support of MMC operations, per SFY.<sup>1,2</sup> Administrative expenses include salaries, wages and other benefits, payroll taxes, utilities and maintenance, auditing and other consulting expenses, etc.</p> <p>The external evaluator will calculate inflation adjustments as necessary.</p>
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>MCO Financial Statistical Reports</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	Type of administrative expenditures, where applicable
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> </ul>



<b>Measure 9.1.2</b>	<b>MCO administrative costs</b>
<b>Interpretation</b>	This measure is a director indicator of the administrative costs of implementing MMC, which operates under the authority of the Demonstration.
<b>Benchmark</b>	None

*Notes.* <sup>1</sup> MCOs report administrative costs on State Fiscal Year (September 1 – August 31) cycles. As a result, post-period does not align with DYs. <sup>2</sup> Due to changes in MCO-required reporting over time, MCO administrative costs may not be comparable across all SFYs. MCO=Managed care organization; MMC=Medicaid managed care; SFY=State Fiscal Year, September 1-August 31; DTA=Descriptive trend analysis.

### **Evaluation Question 10. How do the funding pools administered through the Demonstration support providers and overall Medicaid program sustainability?**

#### **H10.1. The Demonstration leverages savings in health care service expenditures to administer quality-based payment systems and supplemental funding pools.**

<b>Measure 10.1.1</b>	<b>Total expenditures for DSRIP, DPPs, and SPPs</b>
<b>Definition</b>	Total expenditures per DY for the quality-based payment systems and supplemental payment pools administered through the Demonstration.
<b>Study Population</b>	DPP providers; DSRIP providers; PHP-CCP program providers; UC program providers
<b>Measure Steward or Source</b>	N/A
<b>Technical Specifications</b>	<p>Total expenditures for DSRIP, DPPs, UC program, and PHP-CCP program per DY.</p> <p>Total expenditures should be presented for each program and summed across all programs.</p> <p>The external evaluator will calculate inflation adjustments as necessary.</p>
<b>Exclusion Criteria</b>	Expenditures associated with quality-based payment systems not directly funded through the Demonstration (e.g., APMs)
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>Budget neutrality worksheet (quarterly version)</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	<ul style="list-style-type: none"> <li>Type of payment system or funding pool administered through the Demonstration</li> </ul>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>Descriptive statistics</li> <li>DTA</li> </ul>

<b>Measure 10.1.1</b>	<b>Total expenditures for DSRIP, DPPs, and SPPs</b>
<b>Interpretation</b>	This measure is a director indicator of the quality-based payment systems and supplemental funding pools available through savings in health care service expenditures under the Demonstration.
<b>Benchmark</b>	None

*Notes.* DSRIP=Delivery System Reform Incentive Payment; DPP=Directed Payment Program; SPP=Supplemental Payment Program; DY=Demonstration year, October 1-September 30; PHP-CCP=Public Health Providers Charity Care Pool; UC=Uncompensated Care; APM=Alternative Payment Model; DTA=Descriptive trend analysis.

<b>Measure 10.1.2</b>	<b>Medicaid providers receiving payments through DSRIP, DPPs, and SPPs</b>
<b>Definition</b>	Total number of providers per DY enrolled in quality-payment systems and supplemental payment pools administered through the Demonstration.
<b>Study Population</b>	DPP providers; DSRIP providers; PHP-CCP program providers; UC program providers
<b>Measure Steward or Source</b>	N/A
<b>Technical Specifications</b>	<p>Unique count of providers enrolled in DSRIP, any DPP program, UC program, or PHP-CCP program per DY/SFY.<sup>1</sup> Providers enrolled in multiple programs should only be counted once.</p> <p>Provider counts should be presented for each program and summed across all programs.</p>
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• DSRIP and DPP administrative data</li> <li>• DSH/UC application</li> <li>• PHP-CCP application</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	<ul style="list-style-type: none"> <li>• Type of payment system or funding pool administered through the Demonstration</li> </ul>
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Descriptive statistics</li> <li>• DTA</li> </ul>
<b>Interpretation</b>	This measure is a director indicator of participation in quality-based payment systems and supplemental funding pools available through savings in health care service expenditures under the Demonstration.
<b>Benchmark</b>	None

*Notes.* <sup>1</sup> DPPs operate on a State Fiscal Year (September 1-August 31) cycles. DSRIP=Delivery System Reform Incentive Payment; DPP=Directed Payment Program; SPP=Supplemental Payment Program; DY=Demonstration year, October 1-September 30; PHP-CCP=Public Health Providers Charity Care Pool; UC=Uncompensated Care; SFY=State fiscal year, September 1-August 31; DSH=Disproportionate Share Hospital; DTA=Descriptive trend analysis.

## **H10.2. The quality-based payment systems and supplemental funding pools administered through the Demonstration support Medicaid provider operations and sustainability.**

<b>Measure 10.2.1</b>	<b>Perceived successes and challenges of DPPs and SPPs</b>
<b>Definition</b>	Perceived successes and challenges of DPPs and SPPs in supporting: <ul style="list-style-type: none"> <li>• Provider operations</li> <li>• Provider sustainability</li> </ul>
<b>Study Population</b>	DPP providers; PHP-CCP program providers; UC program providers
<b>Measure Steward or Source</b>	N/A – External evaluator will develop survey
<b>Technical Specifications</b>	DPP, PHP-CCP, and UC program providers will be asked to provide feedback on the successes and challenges of DPPs and SPPs in supporting provider operations and provider sustainability.
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>• Provider Survey (to be developed by external evaluator)</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	Respondent characteristics (participating program, provider type, region, etc.), where applicable
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>• Thematic content analysis</li> </ul>
<b>Interpretation</b>	Respondent perspectives will provide direct insight into successes and challenges of DPPs and SPPs in supporting Medicaid provider operations and sustainability.
<b>Benchmark</b>	None

*Notes.* DPP=Directed Payment Program; SPP=Supplemental Payment Program; UC=Uncompensated Care; PHP-CCP=Public Health Provider-Charity Care Pool.

<b>Measure 10.2.2</b>	<b>Provider perspectives on state priorities and policy development</b>
<b>Definition</b>	Provider perspectives on and recommendations for state priorities and policy development related to supporting to Medicaid providers in Texas.
<b>Study Population</b>	DPP providers; PHP-CCP program providers; UC program providers
<b>Measure Steward or Source</b>	N/A – External evaluator will develop survey
<b>Technical Specifications</b>	DPP, PHP-CCP, and UC program providers will be asked to share perspectives and recommendations for state priorities and policy development related to supporting Medicaid providers.

<b>Measure 10.2.2</b>	<b>Provider perspectives on state priorities and policy development</b>
<b>Exclusion Criteria</b>	None
<b>Data Source(s)/Data Collection Methods</b>	<ul style="list-style-type: none"> <li>Provider Survey (to be developed by external evaluator)</li> </ul>
<b>Comparison Group(s)/ Subgroup(s)</b>	Respondent characteristics (provider type, region, etc.), where applicable
<b>Analytic Methods</b>	<ul style="list-style-type: none"> <li>Thematic content analysis</li> </ul>
<b>Interpretation</b>	Respondent perspectives will provide direct insight into provider considerations for state programs that support Medicaid providers in Texas.
<b>Benchmark</b>	None

*Notes.* DPP=Directed Payment Program; UC=Uncompensated Care; PHP-CCP=Public Health Provider-Charity Care Pool.

## Appendix F. List of Acronyms

Acronym	Full Name
<b>ACIA</b>	Average Commercial Incentive Award
<b>ADHD</b>	Attention-Deficit/Hyperactivity Disorder
<b>AHRQ</b>	Agency for Healthcare Research and Quality
<b>AI</b>	Administrative Interview
<b>AOD</b>	Alcohol or Other Drug
<b>APM</b>	Alternative Payment Model
<b>BP</b>	Blood Pressure
<b>CAHPS®</b>	Consumer Assessment of Healthcare Providers and Systems
<b>CAUTI</b>	Catheter-Associated Urinary Tract Infection
<b>CCBHC</b>	Certified Community Behavioral Health Clinic
<b>CDC</b>	Comprehensive Diabetes Care
<b>CDC</b>	Centers for Disease Control and Prevention
<b>CHIP</b>	Children's Health Insurance Program
<b>CHIRP</b>	Comprehensive Hospital Increased Reimbursement Program
<b>CLABSI</b>	Central Line-Associated Blood Stream Infection
<b>CMHC</b>	Community Mental Health Clinic
<b>CMS</b>	Centers for Medicare and Medicaid Services
<b>CPT</b>	Current Procedural Terminology Code
<b>DMO</b>	Dental Maintenance Organization
<b>DPP</b>	Directed Payment Program
<b>DPP BHS</b>	Directed Payment Program for Behavioral Health Services
<b>DRTS</b>	Demand Response Transportation Services
<b>DSH</b>	Disproportionate Share Hospital
<b>DSRIP</b>	Delivery System Reform Incentive Payment
<b>DTA</b>	Descriptive Trend Analysis
<b>DY</b>	Demonstration Year
<b>ED</b>	Emergency Department
<b>EQRO</b>	External Quality Review Organization
<b>FFS</b>	Fee-For-Service
<b>FFY</b>	Federal Fiscal Year
<b>FSR</b>	Financial Statistical Report

<b>Acronym</b>	<b>Full Name</b>
<b>HbA1c</b>	Hemoglobin A1c
<b>HCAHPS®</b>	Hospital Consumer Assessment of Healthcare Providers and Systems
<b>HCBS</b>	Home and Community-Based Services
<b>HEDIS®</b>	Healthcare Effectiveness Data and Information Set
<b>HHSC</b>	Texas Health and Human Services Commission
<b>HRI</b>	Health-Related Institution
<b>ICD-10-CM</b>	International Classification of Diseases, 10 <sup>th</sup> Revision, Clinical Modification Code
<b>ICHP</b>	Institute for Child Health Policy
<b>ICU</b>	Intensive Care Unit
<b>IDD</b>	Intellectual or Developmental Disability
<b>IMD</b>	Institution for Mental Diseases
<b>IME</b>	Indirect Medical Education
<b>IPSD</b>	Index Prescription Start Date
<b>ITS</b>	Interrupted Time Series
<b>LBHA</b>	Local Behavioral Health Authority
<b>LHD</b>	Local Health Department
<b>LIU</b>	Low-Income Uninsured
<b>LMHA</b>	Local Mental Health Authority
<b>LTSS</b>	Long-Term Services and Supports
<b>MCO</b>	Managed Care Organization
<b>MDS</b>	Minimum Data Set
<b>MEG</b>	Medicaid Eligibility Group
<b>MMC</b>	Medicaid managed care
<b>MTO</b>	Managed Transportation Organization
<b>NCQA</b>	National Committee for Quality Assurance
<b>NEMT</b>	Non-Emergency Medical Transportation
<b>NICU</b>	Neonatal Intensive Care Unit
<b>NPI</b>	National Provider Identifier
<b>P4Q</b>	Pay-for-Quality
<b>PIP</b>	Performance Improvement Project
<b>PCN</b>	Patient Control Number
<b>PDI</b>	Pediatric Quality Indicator

<b>Acronym</b>	<b>Full Name</b>
<b>PHD</b>	Public Health District
<b>PHP-CCP</b>	Public Health Provider Charity Care Pool
<b>PMPM</b>	Per Member Per Month
<b>PPA</b>	Potentially Preventable Admission
<b>PPC</b>	Potentially Preventable Complication
<b>PPE</b>	Potentially Preventable Event
<b>PPR</b>	Potentially Preventable Readmission
<b>PPV</b>	Potentially Preventable Emergency Department Visit
<b>PQI</b>	Prevention Quality Indicator
<b>QAPI</b>	Quality Assurance and Performance Improvement
<b>QIPP</b>	Quality Incentive Payment Program
<b>RAPPS</b>	Rural Access to Primary and Preventive Services
<b>RHC</b>	Rural Health Clinic
<b>RUCC</b>	Rural-Urban Continuum Codes
<b>SDA</b>	Service Delivery Area
<b>SFY</b>	State Fiscal Year
<b>SPP</b>	Supplemental Payment Program
<b>SQL</b>	Structured Query Language
<b>STC</b>	Special Terms and Conditions
<b>THCIC</b>	Texas Health Care Information Collection
<b>THLC</b>	Texas Healthcare Learning Collaborative
<b>TIPPS</b>	Texas Incentives for Physician and Professional Services
<b>TMHP</b>	Texas Medicaid and Healthcare Partnership
<b>TNC</b>	Transportation Network Companies
<b>TPI</b>	Texas Provider Identifier
<b>UC</b>	Uncompensated Care
<b>UHRIP</b>	Uniform Hospital Rate Increase Program
<b>WOW</b>	Without Waiver
<b>WW</b>	With Waiver

## Appendix G. References

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**From:** [Montalbano, Kathi \(HHSC\)](#)  
**To:** [CMS State Directed Payment](#); [Caruthers, Courtney \(HHSC\)](#); [Young, Gary \(HHSC\)](#)  
**Cc:** [Grady, Victoria C \(HHSC\)](#); [HHSC TX Medicaid Waivers](#); [Giles, John \(CMS/CMCS\)](#); [Snyder, Laura M. \(CMS/CMCS\)](#); [Greenfield, Eli S. \(CMS/CMCS\)](#); [CMS MCOG DMCO Actions](#); [Jones, Angela F. \(CMS/CMCS\)](#); [Kristian, Diona \(CMS/CMCS\)](#); [Bilse, Brittani \(HHSC\)](#); [Zalkovsky, Emily \(HHSC\)](#); [Diseker, Sarah \(HHSC\)](#); [Loizias, Alexandra \(CMS/CMCS\)](#)  
**Subject:** RE: Texas SFY 2022 CHIRP Preprint for CMS  
**Date:** Wednesday, July 14, 2021 4:42:20 PM  
**Attachments:** [TX CHIRP Round 3 Question Set for State State Responses final.docx](#)  
[Copy of Attachment C - CHIRP Rate Estimates and Payment Levels 07.09.2021.xlsx](#)

Good afternoon Juliet,  
 Attached are the final CHIRP responses along with one revised preprint attachment. Both files are listed below.

- Round 3 CHIRP Questions – State Responses
- Revised Attachment C – CHIRP Rate Estimates and Payment Levels

Thanks.

*Kathi Montalbano*

Manager, Policy Development Support

Texas Health and Human Services Commission

Medicaid/CHIP Division

512-730-7409

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**From:** CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>

**Sent:** Thursday, July 8, 2021 11:32 AM

**To:** Caruthers, Courtney (HHSC) <Courtney.Caruthers@hhs.texas.gov>; Montalbano, Kathi (HHSC) <Kathi.Montalbano@hhs.texas.gov>; Young, Gary (HHSC) <gary.young@hhs.texas.gov>

**Cc:** Grady, Victoria C (HHSC) <Victoria.Grady@hhs.texas.gov>; HHSC TX Medicaid Waivers <TX\_Medicaid\_Waivers@hhs.texas.gov>; Giles, John (CMS/CMCS) <John.Giles1@cms.hhs.gov>; Snyder, Laura M. (CMS/CMCS) <Laura.Snyder1@cms.hhs.gov>; Greenfield, Eli S. (CMS/CMCS) <Eli.Greenfield@cms.hhs.gov>; CMS MCOG DMCO Actions <MCOGDMCOActions@cms.hhs.gov>; Jones, Angela F. (CMS/CMCS) <Angela.Jones2@cms.hhs.gov>; Kristian, Diona (CMS/CMCS) <Diona.Kristian@cms.hhs.gov>; Bilse, Brittani (HHSC) <Brittani.Bilse@hhs.texas.gov>; Zalkovsky, Emily (HHSC) <Emily.Zalkovsky@hhs.texas.gov>; Diseker, Sarah (HHSC) <Sarah.Diseker@hhs.texas.gov>; CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>; Loizias, Alexandra (CMS/CMCS) <Alexandra.Loizias@cms.hhs.gov>

**Subject:** RE: Texas SFY 2022 CHIRP Preprint for CMS

Dear Texas team,

Attached are CMS' third round of questions on your CHIRP 438.6(c) state directed payment submission. Third round questions are highlighted in yellow and labeled as third round questions. If possible, please respond to this question set by **Monday, July 19th**. If you have any questions, etc., please let us know.

Sincerely,

Juliet

**From:** Caruthers,Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>

**Sent:** Friday, June 11, 2021 1:03 PM

**To:** CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>; Montalbano,Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Young,Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>

**Cc:** Grady,Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Giles, John (CMS/CMCS) <[john.giles1@cms.hhs.gov](mailto:john.giles1@cms.hhs.gov)>; Snyder, Laura M. (CMS/CMCS) <[Laura.Snyder1@cms.hhs.gov](mailto:Laura.Snyder1@cms.hhs.gov)>; Kuhn, Juliet L. (CMS/CMCS) <[Juliet.Kuhn@cms.hhs.gov](mailto:Juliet.Kuhn@cms.hhs.gov)>; Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>; CMS MCOG DMCO Actions <[MCOGDMCOActions@cms.hhs.gov](mailto:MCOGDMCOActions@cms.hhs.gov)>; Jones, Angela F. (CMS/CMCS) <[Angela.Jones2@cms.hhs.gov](mailto:Angela.Jones2@cms.hhs.gov)>; Kristian, Diona (CMS/CMCS) <[diona.kristian@cms.hhs.gov](mailto:diona.kristian@cms.hhs.gov)>; Bilse,Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>; Zalkovsky,Emily (HHSC) <[Emily.Zalkovsky@hhs.texas.gov](mailto:Emily.Zalkovsky@hhs.texas.gov)>; Diseker,Sarah (HHSC) <[Sarah.Diseker@hhs.texas.gov](mailto:Sarah.Diseker@hhs.texas.gov)>; Caruthers,Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>

**Subject:** RE: Texas SFY 2022 CHIRP Preprint for CMS

Good afternoon, please find attached the state's responses to the CHIRP round 2 questions, along a zipped file containing the complete CHIRP preprint packet for SFY 2022. Below we have noted if an attachment has been updated, or is new, since the initial preprint submission to CMS.

- CHIRP Preprint PDF: [The following updates were made to the preprint PDF:](#)
  - [Questions 4, 4a and 4b](#) – Updated the amounts to reflect the final rate increases.
  - [Question 6bi](#) – Updated the response to the rating periods previously approved by CMS. The initial preprint had SFY 2017-SFY 2021, but the correct rating periods are SFY 2018-SFY 2021.
  - [Question 19d](#) – Updated the response to reference new Attachment K.
  - [Question 42, Table 7](#) – Updated the response to reference new Attachment L.
- Attachment A – CHIRP Risk Group: [No changes.](#)
- Attachment B – CHIRP Preprint Question 8: [Updated the response as CMS requested in round 2 question 3a.](#)
- Attachment C – CHIRP Rate Estimates and Payment Levels: [The file contains the final rate increases, as well as two new tabs, "UPL Summary" and "CHIRP Payment Calc" which are referenced in the state's responses to the round 2 questions.](#)
- Attachment D – CHIRP Preprint Question 20c: [No changes.](#)
- Attachment E – IGT Entities: [The file was updated to reflect the IGT amounts received for the first half of the program year.](#)
- Attachment F – Local Provider Participation Funds: [No changes.](#)
- Attachment G – CHIRP Preprint Question 41: [No changes.](#)
- Attachment H – CHIRP Preprint Question 43 : [No changes.](#)
- Attachment I – CHIRP Evaluation Plan: [This is same revised evaluation plan HHSC submitted with its responses to the round 1 questions.](#)
- Attachment J – UHRIP Evaluation Report: [No changes.](#)

- Attachment K – Preprint Question 19d: This is a new attachment and contains the updated response to preprint question 19d as CMS requested in round 2 question 5a.

Attachment L – Preprint Question 42 Table 7: This is a new attachment and contains the response to preprint question 42, Table 7 (Quality Strategy Goals and Objectives). The Table has the same updated goals and objectives the submitted with its responses to the round 1 questions.

Thank you.

*Courtney Caruthers*

*1115 Waiver Specialist, Policy Development Support*

*Medicaid/CHIP*

*Health and Human Services Commission*

*Office 512-424-6514 \*currently working remotely*

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**From:** CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>

**Sent:** Friday, May 28, 2021 9:10 AM

**To:** Montalbano,Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Young,Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>

**Cc:** Grady,Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>; Caruthers,Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>; Snyder, Laura M. (CMS/CMCS) <[Laura.Snyder1@cms.hhs.gov](mailto:Laura.Snyder1@cms.hhs.gov)>; Kuhn, Juliet L. (CMS/CMCS) <[Juliet.Kuhn@cms.hhs.gov](mailto:Juliet.Kuhn@cms.hhs.gov)>; Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>; CMS MCOG DMCO Actions <[MCOGDMCOActions@cms.hhs.gov](mailto:MCOGDMCOActions@cms.hhs.gov)>; Jones, Angela F. (CMS/CMCS) <[Angela.Jones2@cms.hhs.gov](mailto:Angela.Jones2@cms.hhs.gov)>; Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>; Bilse,Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>; Zalkovsky,Emily (HHSC) <[Emily.Zalkovsky@hhs.texas.gov](mailto:Emily.Zalkovsky@hhs.texas.gov)>; CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>

**Subject:** RE: Texas SFY 2022 CHIRP Preprint for CMS

Hi Gary and Texas team,

Attached are CMS' second round of questions on your CHIRP 438.6(c) state directed payment submission. Second round questions are in green and labeled as second round questions.

If possible, please respond to this question set by Friday, June 11th. If you have any questions, etc., please let us know. We are actively reviewing the state's responses for the state's other 4 proposals and should have any additional questions on the QIPP responses ready for the state next.

Sincerely,

Laura

---

**From:** CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>

**Sent:** Thursday, May 6, 2021 8:51 AM

**To:** Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>

**Cc:** Grady, Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>; Caruthers, Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Giles, John (CMS/CMCS) <[john.giles1@cms.hhs.gov](mailto:john.giles1@cms.hhs.gov)>; Snyder, Laura M. (CMS/CMCS) <[Laura.Snyder1@cms.hhs.gov](mailto:Laura.Snyder1@cms.hhs.gov)>; Kuhn, Juliet L. (CMS/CMCS) <[Juliet.Kuhn@cms.hhs.gov](mailto:Juliet.Kuhn@cms.hhs.gov)>; Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>; CMS MCOG DMCO Actions <[MCOGDMCOActions@cms.hhs.gov](mailto:MCOGDMCOActions@cms.hhs.gov)>; Jones, Angela F. (CMS/CMCS) <[Angela.Jones2@cms.hhs.gov](mailto:Angela.Jones2@cms.hhs.gov)>; Kristian, Diona (CMS/CMCS) <[diona.kristian@cms.hhs.gov](mailto:diona.kristian@cms.hhs.gov)>; Bilse, Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>; Zalkovsky, Emily (HHSC) <[Emily.Zalkovsky@hhs.texas.gov](mailto:Emily.Zalkovsky@hhs.texas.gov)>; CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>

**Subject:** RE: Texas SFY 2022 CHIRP Preprint for CMS

Thank you Kathi, acknowledging receipt.

Juliet

---

**From:** Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>

**Sent:** Wednesday, May 5, 2021 5:18 PM

**To:** CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>; Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>

**Cc:** Grady, Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>; Caruthers, Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>; Snyder, Laura M. (CMS/CMCS) <[Laura.Snyder1@cms.hhs.gov](mailto:Laura.Snyder1@cms.hhs.gov)>; Kuhn, Juliet L. (CMS/CMCS) <[Juliet.Kuhn@cms.hhs.gov](mailto:Juliet.Kuhn@cms.hhs.gov)>; Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>; CMS MCOG DMCO Actions <[MCOGDMCOActions@cms.hhs.gov](mailto:MCOGDMCOActions@cms.hhs.gov)>; Jones, Angela F. (CMS/CMCS) <[Angela.Jones2@cms.hhs.gov](mailto:Angela.Jones2@cms.hhs.gov)>; Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>; Bilse, Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>; Zalkovsky, Emily (HHSC) <[Emily.Zalkovsky@hhs.texas.gov](mailto:Emily.Zalkovsky@hhs.texas.gov)>

**Subject:** RE: Texas SFY 2022 CHIRP Preprint for CMS

Good afternoon Juliet,

Please find the attached with HHSC's responses to the first round of questions on the CHIRP preprint for state fiscal year 2022. The attached includes:

- TX CHIRP Round 1 Question Set\_State responses\_final\_05.05.21
- CHIRP Round 1 State Responses\_ Attachment 1 (this attachment contains the additional exhibits requested by CMS and revised information for preprint questions 19b, 21, and 35a)
- CHIRP Round 1 State Responses\_ Attachment 2 - CHIRP Evaluation Plan Revision
- CHIRP Round 1 State Responses\_ Attachment 3 - Texas Medicaid Healthcare Quality Goals Guide 2021

Thanks.

*Kathi Montalbano*

Manager, Policy Development Support

Texas Health and Human Services Commission

Medicaid/CHIP Division

512-730-7409

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**From:** CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>

**Sent:** Wednesday, April 21, 2021 3:44 PM

**To:** Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>

**Cc:** Grady, Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>; Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers, Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>; Snyder, Laura M. (CMS/CMCS) <[Laura.Snyder1@cms.hhs.gov](mailto:Laura.Snyder1@cms.hhs.gov)>; Kuhn, Juliet L. (CMS/CMCS) <[Juliet.Kuhn@cms.hhs.gov](mailto:Juliet.Kuhn@cms.hhs.gov)>; Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>; CMS MCOG DMCO Actions <[MCOGDMCOActions@cms.hhs.gov](mailto:MCOGDMCOActions@cms.hhs.gov)>; Jones, Angela F. (CMS/CMCS) <[Angela.Jones2@cms.hhs.gov](mailto:Angela.Jones2@cms.hhs.gov)>; Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>; CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>

**Subject:** RE: Texas SFY 2022 CHIRP Preprint for CMS

Hi Gary and Texas team,

Attached is CMS' initial questions on your CHIRP 438.6(c) state directed payment submission. Our questions are geared to be sure that we understand the submission, and we are happy to setup a call with the state to walk through the questions if helpful.

If possible, please respond to this question set by Wednesday, May 5<sup>th</sup>. We recognize that there are a number of detailed questions; we are happy to work with the state on timelines for responses if May 5<sup>th</sup> is not possible. If you have any questions, etc., please let us know. We are actively working on the question sets for the state's other 4 proposals and should have the QIPP question set ready for the state next week.

Sincerely,

Juliet

**From:** CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>

**Sent:** Friday, March 19, 2021 11:19 AM

**To:** Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>

**Cc:** Grady, Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>; Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers, Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Giles, John (CMS/CMCS) <[john.giles1@cms.hhs.gov](mailto:john.giles1@cms.hhs.gov)>; Snyder, Laura M. (CMS/CMCS) <[Laura.Snyder1@cms.hhs.gov](mailto:Laura.Snyder1@cms.hhs.gov)>; Kuhn, Juliet L. (CMS/CMCS) <[Juliet.Kuhn@cms.hhs.gov](mailto:Juliet.Kuhn@cms.hhs.gov)>; CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>; Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>; CMS MCOG DMCO Actions <[MCOGDMCOActions@cms.hhs.gov](mailto:MCOGDMCOActions@cms.hhs.gov)>; Jones, Angela F. (CMS/CMCS) <[Angela.Jones2@cms.hhs.gov](mailto:Angela.Jones2@cms.hhs.gov)>

**Subject:** RE: Texas SFY 2022 CHIRP Preprint for CMS

Hi Gary – this email serves as confirmation that CHIRP preprint submission has been deemed complete by CMS. We will begin our formal review of the submission as discussed in STC 31.

Thank you,



Juliet

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**From:** Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>  
**Sent:** Thursday, March 18, 2021 9:54 AM  
**To:** Grady, Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>; CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>  
**Cc:** Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers, Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Giles, John (CMS/CMCS) <[john.giles1@cms.hhs.gov](mailto:john.giles1@cms.hhs.gov)>; Snyder, Laura M. (CMS/CMCS) <[Laura.Snyder1@cms.hhs.gov](mailto:Laura.Snyder1@cms.hhs.gov)>; Kuhn, Juliet L. (CMS/CMCS) <[Juliet.Kuhn@cms.hhs.gov](mailto:Juliet.Kuhn@cms.hhs.gov)>  
**Subject:** Re: Texas SFY 2022 CHIRP Preprint for CMS  
Yes. Confirmed.

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**From:** Grady, Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>  
**Sent:** Thursday, March 18, 2021 8:51 AM  
**To:** CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>; Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>  
**Cc:** Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers, Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>; Snyder, Laura M. (CMS/CMCS) <[Laura.Snyder1@cms.hhs.gov](mailto:Laura.Snyder1@cms.hhs.gov)>; Kuhn, Juliet L. (CMS/CMCS) <[Juliet.Kuhn@cms.hhs.gov](mailto:Juliet.Kuhn@cms.hhs.gov)>  
**Subject:** RE: Texas SFY 2022 CHIRP Preprint for CMS  
**Confirmed. Thank you!**  
VG

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Victoria (Weber) Grady  
Director of Provider Finance  
C: (512) 431-7028

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**From:** CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>  
**Sent:** Thursday, March 18, 2021 7:32 AM  
**To:** Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>  
**Cc:** Grady, Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>; Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers, Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>; Snyder, Laura M. (CMS/CMCS) <[Laura.Snyder1@cms.hhs.gov](mailto:Laura.Snyder1@cms.hhs.gov)>; CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>; Kuhn, Juliet L. (CMS/CMCS) <[Juliet.Kuhn@cms.hhs.gov](mailto:Juliet.Kuhn@cms.hhs.gov)>  
**Subject:** RE: Texas SFY 2022 CHIRP Preprint for CMS

Thank you Gary. We are acknowledging receipt of the updated files and will review for completeness. We will follow-up by COB tomorrow (3/19) on the completeness of the submission. We understand that the state updated Attachment E to respond to all items requested in Table 4 and that this is the only revision to the preprint submission package. Can the state please confirm this?

Sincerely,  
Juliet

**From:** Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>

**Sent:** Wednesday, March 17, 2021 4:27 PM

**To:** Kuhn, Juliet L. (CMS/CMCS) <[Juliet.Kuhn@cms.hhs.gov](mailto:Juliet.Kuhn@cms.hhs.gov)>; Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>; CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>

**Cc:** Grady, Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>; Montalbano, Kathi (HHSC)

<[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers, Courtney (HHSC)

<[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; HHSC TX Medicaid Waivers

<[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>

**Subject:** Texas SFY 2022 CHIRP Preprint for CMS

Juliet - In response to your March 11 email (below) HHSC is resubmitting a complete directed payment preprint packet for CHIRP, with modifications requested to Attachment E. to address Table 4.

We look forward to your confirmation that the preprint submission is complete.

Thank you,

Gary

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**From:** Kuhn, Juliet L. (CMS/CMCS) <[Juliet.Kuhn@cms.hhs.gov](mailto:Juliet.Kuhn@cms.hhs.gov)>

**Sent:** Thursday, March 11, 2021 3:52 PM

**To:** Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>

**Cc:** Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers, Courtney (HHSC)

<[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; Grady, Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>;

HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Giles, John (CMS/CMCS)

<[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>; Snyder, Laura M. (CMS/CMCS) <[Laura.Snyder1@cms.hhs.gov](mailto:Laura.Snyder1@cms.hhs.gov)>; Burch

Mack, Rebecca M. (CMS/CMCS) <[Rebecca.BurchMack@cms.hhs.gov](mailto:Rebecca.BurchMack@cms.hhs.gov)>; Greenfield, Eli S. (CMS/CMCS)

<[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>; CMS MCOG DMCO Actions <[MCOGDMCOActions@cms.hhs.gov](mailto:MCOGDMCOActions@cms.hhs.gov)>;

Jones, Angela F. (CMS/CMCS) <[Angela.Jones2@cms.hhs.gov](mailto:Angela.Jones2@cms.hhs.gov)>; CMS State Directed Payment

<[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>; Kuhn, Juliet L. (CMS/CMCS) <[Juliet.Kuhn@cms.hhs.gov](mailto:Juliet.Kuhn@cms.hhs.gov)>

**Subject:** RE: Texas SFY 2022 CHIRP Preprint for CMS

**WARNING:** This email is from outside the HHS system. Do not click on links or attachments unless you expect them from the sender and know the content is safe.

Dear Gary,

Thank you for your submission of a state directed payment preprint under 42 C.F.R. § 438.6(c). We reviewed the submission for completeness and determined the submission to be incomplete. To be considered complete, CMS needs the information that is requested under Table 4 in preprint question 35 specific to IGT Transferring Entities. Attachment E provided by the state includes the names of the transferring entities but does not address the other fields in Table 4 of the preprint. We understand that the collection of IGTs for the program year has not commenced and the state may not have final IGT submission information at this time. However, CMS believes some estimated detail is necessary as we cannot begin review of a preprint with key components of the preprint not completed. We request that the state provide whatever is known at this time related to each entity's operational nature, estimated total dollar amounts to be transferred (which may not be final), and if the entity has general taxing authority, receives appropriations, and is eligible to receive payments under this state directed payment.

As CMS does not believe the state has submitted a complete preprint, the timeframes outlined in the Special Terms and Conditions (STCs) of the [approved 1115 demonstration](#) have not commenced.



For example, within STC 31, CMS is required to furnish to Texas all requests for information needed to assist CMS in evaluating the request within 30 calendar days following receipt of the complete request for approval from the state. CMS does not believe the state has met the threshold of submitting a “complete request for approval” as you have not completed each question on the preprint form states must utilize to request approval for a state directed payment.

Once CMS receives a revised preprint that meets our expectations outlined above and is deemed complete by CMS, CMS will initiate its formal review process of the complete state directed payment preprint submission as discussed in STC 31.

In the interim, CMS would be happy to schedule a call with the state as requested to discuss the incomplete proposal. The following are some dates and times that CMS is available for a call:

3/23: 12-1pm, 2:30-3pm, 4-5pm ET

3/24: 1-2pm ET

3/25: 12-1pm, 1-2pm, 4-5pm ET

3/28: 9-10am, 11-12pm, 1-5pm ET

Please reach out with any questions, concerns, etc., and we look forward to working with Texas on this state directed payment submission.

Thank you,

Juliet

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**F**

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

**Round 3 Question Set**

July 8, 2021

**SECTION I: DATE AND TIMING INFORMATION**

1. Preprint Question 4:

- a. Please describe what is leading to the significant increase in total dollar amounts for this directed payment compared to previous UHRIP proposals, and why these additional funds are necessary.

State Response: Texas hosted a workgroup in the Fall of 2020 to continue efforts to reform the UHRIP program and incorporate aspects of the DSRIP transition. Through the DSRIP program, hospitals were estimated to receive payments of approximately \$2.1 billion associated with various quality improvements in DY10. The DY10 UHRIP estimates were \$2.67 billion. The proposed program size for the rate period for the Comprehensive Hospital Increase Reimbursement Program (CHIRP) substantially overlaps with DY11 and the program is intended to serve as a continuation of the prior UHRIP program with an expansion to incorporate the financial and quality benefits of the DSRIP program that will be ending. The proposed program value of \$5,020,000,000 for state fiscal year 2022 is intended to sustain the existing program size, plus the value of the DSRIP DY10 for hospitals, with increased administrative expenses for Medicaid managed care organizations who will be working with providers to continue the quality improvements that have been incorporated into the program. It is important to note that the \$5,020,000,000 size is an estimate based upon forecasted caseloads and forecasted hospital utilization. Actual payments to MCOs could vary based upon caseload fluctuations, and payments to hospitals by MCOs could vary based upon actual utilization during the rating period.

- b. Please clarify if the estimated total dollar amount provided in response to question 4 includes any allowance for administration, profit margin, or premium tax.

State Response: Yes, the estimated total dollar amount of \$5.02 billion includes all estimated capitation rate costs, including administration, risk margin, and premium tax.

- c. Please provide estimates of the share of the total dollars provided in response to question 4 that is for:

- i. Component 1 (UHRIP)
- ii. Component 2 (ACIA)
- iii. Administration, profit margin, or premium tax.

State Response: Please see the "Total Dollars" tab in Attachment 1. Please note that these numbers have changed since the initial submission of the pre-print based upon actual enrollment applications received for the program.

**SECTION II: TYPE OF STATE DIRECTED PAYMENT**

2. Overarching question: The structure of this payment arrangement is complex. It also seems prone to creating perverse incentives for the plans. For example, the required uniform increases could result in plans negotiating lower base rates with providers subject to the state directed payment.

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

**Round 3 Question Set**

July 8, 2021

- a. Has the state instituted any measures to counteract any such perverse incentives?

State Response: While not specific to the former UHRIP or proposed CHIRP, the Medicaid managed care contracts and the Texas Government Code § 533.005(a)(25), prohibit an MCO from implementing "...significant, non-negotiated, across-the-board Provider reimbursement rate reductions unless: (1) it receives HHSC's prior approval, or (2) the reductions are based on changes to the Medicaid fee schedule or cost containment initiatives implemented by HHSC. For purposes of this requirement an across-the-board rate reduction is a reduction that applies to all similarly-situated providers or types of providers."

The state has not received any formal provider or MCO complaints that contract negotiations have been impeded as a direct response to the prior or proposed pre-print. HHSC will continue to monitor contract compliance, network adequacy, and complaints registered by both members and providers. The state will investigate any concerns that appear to be related to the CHIRP.

- b. Has the state monitored rates paid by plans (e.g. through encounter data submissions) to monitor if the negotiated rates paid by plans have decreased since UHRIP has been implemented?

State Response: No. The state has not undertaken a study to determine whether payment-to-charge ratios have changed since implementation of the UHRIP/CHIRP program. However, since the inception of the UHRIP program, there have been additional appropriations to support rate increases for rural and children's hospitals, so it might be difficult to perform such a study. In discussions with external stakeholders and Medicaid managed care organizations, no participants have raised concerns about widespread modifications to base reimbursement rates agreed to in the underlying in-network contracts between MCOs and providers because of the program.

**CMS Round 2 Question:**

How does the state monitor that the plans are complying with the contract provisions to pay these uniform increases?

**State Round 2 Response:** The state has established contact compliance mechanisms to ensure compliance with all terms in the Medicaid managed care organization contracts, including provisions and requirements related to directed-payment programs. If HHSC identifies non-compliance, e.g. from provider complaints, HHSC will address the non-compliance with the MCO. This can be done through a variety of methods, including providing technical assistance, implementing corrective action plans, or assessing liquidated damages. If a provider does not believe that an MCO is operating in compliance with the program requirements, Medicaid managed care providers can submit complaints and inquiries directly to HHSC Managed Care Compliance and Operations (MCCO). If the complaint is an MCO related issue, a notification letter

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

Round 3 Question Set

July 8, 2021

detailing the issue and providing a due date for response will be sent to the MCO involved with the complaint. Once the MCO responds, HHSC staff will review and determine if all concerns were sufficiently addressed; if not, the specialist will continue researching and communicating with all parties until complete resolution is achieved.

- c. If the state's goal is to increase hospital reimbursement up to a certain level, has the state considered requiring plans to implement a minimum fee schedule (or series of minimum fee schedules) instead of uniform increases?

State Response: The goal of CHIRP is to incentivize hospitals to improve in the quality goals and objectives targeted by the program.

In response to legislative direction, the state has implemented a minimum fee schedule for rural hospitals in accordance with state law that requires a minimum fee schedule as it was believed that these financially vulnerable hospitals could use support in their negotiations with MCOs; however, those actions were not related to the implementation of UHRIP/CHIRP, but were in response to legislative direction to provide additional support to rural hospitals who might be at risk of closures.

Additionally, as the program incorporates additional performance modules and measures, it is important that the program is an "opt-in" and we do not anticipate that a minimum fee schedule would be able to provide the same flexibility that a uniform rate increase does with respect to providers' optional participation in the program components.

3. Preprint Question 8:

- a. Please further describe the methodology used to calculate the ACIA payment increase. In the response, please clarify if the calculation is performed separately for each hospital, or if it is performed for the entire class. As part of the response, please clarify if it is ever possible for the provider reimbursement to exceed the ACR for any specific provider.

State Response: The ACIA rate increase percentage is calculated separately for inpatient and outpatient services at the individual hospital level. The inpatient ACIA increase is determined using a uniform percentage of the inpatient ACR gap. The ACR gap is calculated using the inpatient payment-to-charge ratio of commercial insurance multiplied by the inpatient Medicaid charges, minus inpatient Medicaid payments. If the hospital has a positive ACR gap (i.e., the provider is estimated to receive more from a commercial payor than it received from Medicaid), the inpatient ACIA payment is a uniform percentage of the individual hospital's ACR gap, less the estimated payments received from the UHRIP component. If the inpatient UHRIP payment is greater than the ACR gap, the provider will receive a 0% ACIA rate. All of the steps listed above are identical for the calculation of outpatient ACIA, where outpatient values are used in place of the inpatient values.

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

**Round 3 Question Set**

July 8, 2021

It is never possible for a provider participating in ACIA to receive reimbursement that exceeds ACR.

**CMS Round 2 Question:**

1. Please update the preprint with the additional information provided above.

**State Round 2 Response:** The additional information has been added to the state's response to preprint question 8 (please see revised Attachment B).

**CMS Round 3 Question:** The state above indicates that "the inpatient/outpatient ACIA increase is determined using a uniform percentage of the inpatient/outpatient ACR gap". Can the state please clarify if the reference to "70% of ACR before Cutback" in column R within tab "CHIRP Payment Calc" of Attachment C is this "uniform percentage"?

**State Round 3 Response:** Yes, it is.

2. From the state's response, we understand that a provider could have a 0% ACIA increase but have an inpatient URHIP increase that could potentially result in payment that is over the ACR. Is this correct? Yes.
  - a. If yes, would these providers not participate in ACIA and therefore not need to report on the ACIA quality measures? Correct, these providers are viewed as non-participants in ACIA and therefore do not need to report on the ACIA quality measures.

**CMS Round 3 Question:** Why does the state believe it is appropriate that providers can receive reimbursement that exceeds the ACR under UHRIP (without reporting or satisfying the additional quality measures that providers participating in ACIA will need to do), but providers will not be able to receive reimbursement that exceeds the ACR under ACIA?

**State Round 3 Response:** UHRIP and ACIA are distinct program components that confer to participants separate percentage rate increases. A provider can participate in UHRIP and not ACIA, as ACIA is considered a voluntary component. While some providers are precluded from receiving a rate increase under ACIA because the sum of their base payment, plus the UHRIP component payment result in a rate increase wherein that provider has no estimated ACR Gap, the provider is in fact not participating in ACIA and should not be required to provide reporting related to that component.

- b. The state notes that there are now 166 individual facilities that are reported as 0% for ACIA. How many of these hospitals would fall into the category of having a UHRIP percentage increase that exceeds the ACR? The most recent

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

**Round 3 Question Set**

July 8, 2021

calculation shows 115 hospitals requesting participation in ACIA as having 0% for ACIA. Of those, 31 hospitals have a UHRIP rate greater than ACR. In the Attachment C, tab “CHIRP Payment Calc”, those hospitals can be viewed by filtering on columns Y, AC, AD, and BE.

**CMS Round 3 Question:**

- i. In looking at tab “CHIRP Payment Calc” in Attachment C and filtering columns, Y, AC, and AD, we believe there are 96 hospitals (vs 115) that requested participation in ACIA but have a 0% for ACIA. Can the state please clarify?

**State Round 3 Response:** We have corrected the #n/a error showing up for some providers in column Y, and that results in 98 providers requesting to participate in ACIA but having 0%.

- ii. Besides having a UHRIP rate greater than ACR, what are the reasons for the rest of the 96 (or 115 hospitals) having a 0% for ACIA?

**State Round 3 Response:** Some providers did not have commercial data for the time period that was requested, either due to a change of ownership or due to being a new facility.

- b. Please affirm that the payments required under this payment arrangement will only be made for Medicaid services on behalf of Medicaid beneficiaries covered under the Medicaid managed care contract for the SFY 2022 rating period only, and that the payments will not be made on behalf of individuals who are uninsured, covered for such services by another insurer (e.g. Medicare), nor Medicaid services provided through the state’s fee-for-service program.

**State Response:** Texas affirms only in-network Medicaid managed care encounters for the SFY 2022 rating period are eligible for the rate increase.

4. Preprint Question 19b:

- a. Please provide an exhibit showing the average increase for each class for each service in each SDA separately for the mandatory and optional payments and in total.

**State Response:** State Response: Please see the “Avg Increase by SDA and Class” tab in Attachment 1 for the requested exhibit. Please note that these numbers have changed since the initial submission of the pre-print based upon actual enrollment applications received for the program.

**CMS Round 2 Response:** We note that the providers in the MRSA Northeast Non-State-Owned IMD, Harris State-Owned IMD, and MRSA Central State-Owned IMD classes are not participating in UHRIP nor ACIA. Can the state please explain why?

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

**Round 3 Question Set**

July 8, 2021

**State Round 2 Response:** No applications for enrollment were received for the providers of these class and SDA combinations.

- b. Please clarify if the increases for each class, SDA, and component will differ between inpatient and outpatient services. If so, CMS requests the state also provide the exhibit requested above for both inpatient and outpatient services separately.

**State Response:** Yes, rate increases for each class, SDA, and component will differ between inpatient and outpatient services. Please see “Avg Increase by SDA and Class” tab in Attachment 1 for the requested exhibit.

- c. Per the “Q19b CHIRP Rate Increases” tab in Attachment C:
- i. Please explain why the minimum increase for each component of the CHIRP increase for Children’s Hospitals is 0% but the total minimum is 19%.

**State Response:** The modeling has been updated based upon actual enrollment in the program, as shown on the “Revised Question 19b” tab of Attachment 1. The new numbers are as follows: for children's inpatient services, the minimum UHRIP rate is 0%, the minimum ACIA rate is 0%, but the total minimum CHIRP rate is 46%. This data is based on the values presented in the “Revised Q21 Hospital Rates” tab of Attachment 1. NPI 1447355771 Seton Healthcare -Dell Children's Medical Center received a 0% UHRIP rate along with NPI 1437171568 Methodists Childrens Hospital - Covenant Childrens Hospital. However, both of these providers have an ACIA rate, so they do not end up with a 0% inpatient CHIRP rate. NPI 1720480627 Children's Medical Center of Dallas - Children's Medical Center Plano received a 57% inpatient UHRIP rate, but a 0% inpatient ACIA rate, causing the minimum ACIA rate to be 0%. The total minimum rate for inpatient CHIRP Children's hospitals is actually for NPI 1558659714 El Paso Childrens Hospital.

Texas has previously noted that Medicare rates are generally developed with an elderly population, whereas Children’s hospitals may have increased costs (and therefore higher negotiated commercial rates) that reflect the specialty care and services that are being provided for pediatric services.

- ii. Please explain why the maximum CHIRP percentage increase for state owned non-IMD hospitals is 2325% and for urban hospitals it is 3684%.

**State Response:** The modeling has been updated based upon actual enrollment in the program, as shown on the “Revised Question 19b” tab of Attachment 1. The maximum CHIRP rate increase for state-owned non-IMD hospitals is 193% for inpatient services and 192% for outpatient services. The maximum CHIRP rate increase for urban hospitals is 1116% for inpatient services and 2340% for outpatient services. The 2340% increase was based on NPI 1609855139 Baylor Heart and Vascular Center, which reported a very high payment-to-charge ratio

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

**Round 3 Question Set**

July 8, 2021

for commercial insurers and received a UHRIP rate of 37% and an ACIA rate of 2304%. This hospital only had \$8,320 of eligible encounters based on the preliminary data, and its outpatient ACIA dollars is \$191,665, so its ACIA rate is \$191,665 divided by \$8,320 which is 2304%.

These types of variations in provider's ACR data are likely attributed to many varying factors, but Texas believes the Medicaid program is justified in establishing a reimbursement rate that is competitive with other payors in Texas.

**CMS Round 2 Question:** Data appears to be limited for some providers with very low volume. Since this data is used to establish the UHRIP and particularly the ACIA uniform increase percentages, has the state considered the credibility of the data for providers with very high uniform increase percentages? Does the state have plans to conduct any audits on the ACR data provided?

**State Round 2 Response:** The volume of services delivered by a provider is not a measure by which the state examines the veracity of information provided. All hospitals, including those with low volume, are required to maintain all supporting documentation at the hospital for any information provided for the calculation of the ACR gap for a period of no less than 5 years from the date of the application. Providers must also certify that any information provided may be published at the provider level in future reports, audits, or public information requests. The state does not currently plan to conduct audits specifically focused on the information provided in the CHIRP application, however, providers are subject to oversight by the state's Office of Inspector General. If at any point the state discovers that a provider misrepresented the data submitted in the CHIRP application, the provider would be subject to all possible legal and financial remedies, including recoupment of all funds.

**CMS Round 3 Question:** We would strongly recommend that the state consider implementing some form of monitoring or audit to investigate outliers in CHIRP data that is self-reported to the state by the providers.

**State Round 3 Response:** Acknowledged. The state may request technical assistance from CMS on the implementation of monitoring efforts that would be satisfactory to CMS.

- iii. Please explain why the maximum CHIRP percentage increase for state owned non-IMD hospitals is the same as the maximum UHRIP percent increase (i.e., 2325%), when the maximum ACIA percent increase is 184%.

State Response: The modeling has been updated based upon actual enrollment in the program, as shown on the "Revised Question 19b" tab of Attachment 1.



TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

**Round 3 Question Set**

July 8, 2021

The maximum inpatient CHIRP increase is 193% and the maximum inpatient UHRIP increase is 96%. This data is based on the values presented in the “Revised Q21 Hospital Rates” tab of Attachment 1.

## 5. Preprint Question 19d:

- a. The state indicates that the total value of the UHRIP component will be equal to the percentage of the estimated Medicare gap on a per class basis. Can the state explain what is meant by total value? Does this mean the total dollars for all the UHRIP payments made to all hospitals eligible will be equal to the sum of the Medicare gap for each provider class? Additionally, does this mean the Medicare gap is calculated per class across SDAs? Or is the Medicare gap calculated by class within an SDA and then summed across SDAs?

State Response: The total value of the UHRIP component means the total estimated payments for UHRIP. The total dollars in the UHRIP component are equal to a percentage of the Medicare UPL gap not to exceed 100%. This percentage is determined at an SDA and class level. The Medicare gap is calculated separately for inpatient and outpatient services and is aggregated by SDA and class. For example: if the inpatient Medicare gap for a class and SDA totaled \$1 million and the percentage of the Medicare gap was set to 100%, the total inpatient UHRIP value would be set to \$1 million. If the class and SDA had \$5 million in estimated inpatient encounters, the inpatient rate would be 20% (\$1 million divided by \$5 million). The intention of the state is to ensure that UHRIP incentivizes providers to advance certain quality goals and objectives by increasing payments to approximately what Medicare would have paid on the same encounters, aggregated for the class in the SDA.

CMS Round 2 Response: Please add this additional detail to the preprint.

State Round 2 Response: The additional information has been added to the state’s response to preprint question 19d, which is included in new Attachment K.

- b. The state indicates that the allocation of funds across hospital classes will be proportional to the combined Medicare gap of each hospital class within an SDA to the total Medicare gap of all hospital classes within the SDA. Can the state please explain what this means? The allocation methodology seems to differ from the methodology used to develop the total value. Please explain the differences and the state’s rationale.

State Response: The UHRIP component will be calculated on an SDA and class basis for IP and OP services. The percentage of the Medicare gap (not to exceed 100%) will be assigned at the SDA level. Therefore, the Medicare gap in each class and SDA combination will be proportional to the SDA. In the examples provided in the preprint, the Medicare gap was set at 100% for all SDAs.

CMS Round 2 Questions:

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

**Round 3 Question Set**

July 8, 2021

1. In the state's June submission, please provide CMS the final, assigned Medicare gap percentage for each SDA, for inpatient and outpatient services.

**State Round 2 Response:** Attachment C now has an added "UPL Summary" summary tab that lists the UPL percentages by SDA, inpatient and outpatient services.

**CMS Round 3 Questions:** Can the state please provide a brief description of what each column in the table represent?

**State Round 3 Response:** Attachment C has been updated, and the "Summary" tab details the Medicare UPL gaps by SDA/class and Inpatient/Outpatient in columns B and C.

2. CMS's understanding from review of the actuarial certification for the STAR program is that there are some related party arrangements in some SDAs. In the rate certification, the state and the actuary apply adjustments to the base data used for capitation rate setting to ensure that any such payments do not inflate the capitation rates. Is the state concerned that some of the data provided by facilities, including ACR data, have been inflated as a result of related party arrangements? Has the state investigated any potential related party arrangements that may be inflating the ACR or impacting the calculations of the uniform percentage increases for some providers?

**State Round 2 Response:** The state has not examined which providers may also have a related-party commercial insurance plan from which they receive payments but is not concerned at this time. The ACR data collected requires them to report all commercial payments and charges, regardless of who the payer is. Because the reported information includes information from all payers, not just the top five or some other subset, the state believes that the aggregate nature of the payment-to-charge ratio calculation should dilute any such anomalies in payment, if they were to exist.

**SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS**

6. Preprint Question 20:

- a. Are there any provider classes new to this preprint submission?

**State Response:** Yes; the prior program periods used class definitions that did not align with the class definitions in the Texas Medicaid state plan. The class definitions used for this program period will reduce the number of distinct classes from 8 to 6.

- b. What overlap (if any) is there between provider classes and how is this accounted for in the provider payment analysis?

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

Round 3 Question Set

July 8, 2021

State Response: There is no overlap between classes.

- c. Please clarify why the University of Texas Southwestern hospital is a state-owned acute care hospital, but not currently included in the definition of “State Teaching Hospital” in the state plan.

State Response: The hospital owned by UT Southwestern was originally a non-profit hospital that was purchased by UT Southwestern in 2005. Texas has not updated the state plan to reflect that the hospital owned by UT Southwestern is a state-owned teaching hospital. Texas is considering updating the state plan to reflect this in the future.

7. Preprint Question 21: The state indicates in response to preprint question 21, *“HHSC will not enroll providers or collect final data to calculate the ACR gap until April 2021, but HHSC is including an estimate of the program amounts and rate increases, based upon optional survey data that was collected to assist the state in designing the program. The state will plan to resubmit final rate increase percentages following enrollment into the program and recalculation of the rate increases using more current data. We will submit this information no later than June 10, 2021.”*

Please note that CMS will not be able to approve this state directed payment proposal until we receive the final rate increase percentages.

We also understand that many of the figures provided in this submission are subject to change once the final rate increase percentages are finalized. Please clarify each figure that is subject to change as the payment arrangement is finalized, including but not limited to the estimate of the total dollar amount of the payment arrangement, the magnitude of the payment increases for each component/class/SDA/hospital, the reimbursement rate analysis, etc., and confirm that these figures will be updated with the final submission. For every value subject to change, please describe the potential magnitude of the change.

State Response: The total dollar amount of the program will not exceed \$5.02 billion in the June submission. All rate increase percentages (UHRIP, ACIA, and the overall rate) could increase or decrease as our internal and external actuaries finalize the encounters that will be used in the final capitated rates for the SFY 2022 rating period. The number of providers included in the program could decrease if we are notified that anyone wishes to withdraw their application between now and when capitated rates are finalized. The state’s response to question 8 indicates the total number of providers enrolled.

HHSC must also wait to determine if there are any statutory changes, including changes that could impact reimbursement rates or payments, that result from the Texas Legislature, which is currently in session.

These figures will be updated in the final submission. In addition, after the June submission, total dollar amounts could increase or decrease again since the encounters used are estimated.

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

**Round 3 Question Set**

July 8, 2021

However, we do not anticipate that any changes would be significant, as typically the final values have been substantially similar to the preliminary values.

**CMS Round 2 Question:** Please note, CMS will not be able to make a final determination on the state's preprint until we receive final data. When the state provides the final rate increases in June, please update the reimbursement rate analysis. Since the ACIA percent increases are calculated at a provider-specific level, we request that the reimbursement level analysis be at a provider-specific level, in addition to the summary level information that the state has provided to-date.

**State Round 2 Response:** Please see the final rate increases and updated reimbursement rate analysis in Attachment C.

**CMS Round 3 Question:** The 'Q23 Payment Levels' tab in Attachment C seems to imply that the CHIRP will result in total reimbursement that exceeds ACR on a class level (not just individual hospital level). Is this an accurate conclusion?

**State Round 3 Response:** No, this is not an accurate conclusion. Please see the revised Attachment C, which has the payment levels divided into 6 tabs – Q23\_IP UHRIP Payment Levels, Q23\_OP UHRIP Payment Levels, Q23\_IP ACIA Payment Levels, Q23\_OP ACIA Payment Levels, Q23\_IP CHIRP Payment Levels, and Q23\_OP CHIRP Payment Levels. Since the question is specifically about ACR, please look at the Q23\_IP CHIRP Payment Levels and the Q23\_OP CHIRP Payment Levels tabs. The highest payment level for the IP CHIRP Payment Level tab is 99%, and the highest payment level for the OP CHIRP Payment Level tab is 98%. This tab compares the ACR to the total UHRIP and ACIA payments for all providers that participated in both UHRIP and ACIA.

8. Preprint Question 21: We understand that hospitals in Texas were required to submit an enrollment application by April 5, 2021. Can the state please describe the type of response received, including hospital's interest to participate in the optional ACIA component? Specifically, how many hospitals will be participating in UHRIP and how many in ACIA?

**State Response:** HHSC received 412 provider applications for CHIRP. Of those 412, 300 of the providers will be participating in the optional ACIA component.

**CMS Round 3 Question:** In looking at tab "CHIRP Payment Calc" in Attachment C, can the state please clarify why there are 419 total hospitals listed since we previously understood there were 412 provider applicants?

**State Round 3 Response:** The state allowed a small number of providers to submit late applications in order to participate in the program.

9. Preprint Question 21 (Attachment C): According to the information provided by the state in this excel file:

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

## Round 3 Question Set

July 8, 2021

- a. It appears that 551 hospitals will participate in CHIRP. Is this an accurate final count? If not, please indicate when the state will provide a final number.

State Response: 412 providers enrolled in CHIRP.

- b. It appears that the table provides the percentage increase the state would require under component 1 for each individual hospital based on its provider class and SDA and then the additional percentage increase that the hospital would qualify under ACIA. Is this correct? For example, is it correct to say that the state Medicaid managed care plans would be required to pay the Parkland Memorial Hospital – Parkland Memorial – Rehab Unit (NPI 1982666111) a 170% increase from the negotiated rate as part of the UHRIP component plus an additional 2% increase from the negotiated rates as part of the ACIA component? In other words, assuming this facility met the requirements for the 2 components – the plans would be required to pay an additional increase equal to 172% of the rates negotiated by the plans and providers.

State Response: This was correct at the time of the initial submission of the pre-print. However, the modeling has been updated based upon actual enrollment in the program, as shown on the “Revised Q21 Hospital Rates” tab of Attachment 1. The modeling has also changed to provide rates for inpatient services (IP) and outpatient services (OP). The updated percentages are as follows:

	UHRIP Rate	ACIA Rate	Total CHIRP Rate Increase
Inpatient Services	65%	42%	107%
Outpatient Services	37%	32%	69%

- c. In the example above, would the 172% increase be applied to both inpatient services and outpatient services individually? If not, please indicate what the increases are for each service.

State Response: This was correct at the time of the initial submission of the pre-print. However, the modeling has been updated based upon actual enrollment in the program, as shown on the “Revised Q21 Hospital Rates” tab of Attachment 1. The modeling has also changed to provide IP and OP rates. The total IP CHIRP rate increase would be 107% and the total OP CHIRP rate increase would be 69% for Parkland Memorial Hospital - Parkland Memorial - Rehab Unit.

- d. Are the details provided in Q21 final increases or are these subject to change per the note included above? If subject to change, please note that CMS will not be able to approve this state directed payment proposal until we receive the final rate increase percentages.

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

## Round 3 Question Set

July 8, 2021

State Response: The rates shown in the “Revised Q21 Hospital Rates” tab of Attachment 1 are subject to change if the encounters used in the determination of the SFY 2022 capitation rates are modified. Final rates will be communicated in June 2021.

- e. In review of the data, it appears that the UHRIP increases for each class within each SDA are the same – can the state confirm this is correct? Can the state also confirm that the percentage increases included in the table below are correct?

State Response: The values have been updated in Attachment 1 based upon actual enrollment. The UHRIP rates are calculated at the SDA and class combination level for IP and OP services separately. The percent increases are subject to change based upon data updates as the capitated rates are finalized.

Provider Class	SDA	UHRIP Percentage Increase
Children's Hospital	Bexar	57%
Children's Hospital	Dallas	25%
Children's Hospital	El Paso	37%
Children's Hospital	Harris	19%
Children's Hospital	Lubbock	0%
Children's Hospital	Nueces	21%
Children's Hospital	Tarrant	14%
Children's Hospital	Travis	0%
Non-State-Owned IMD	Bexar	32%
Non-State-Owned IMD	Dallas	35%
Non-State-Owned IMD	El Paso	13%
Non-State-Owned IMD	Harris	29%
Non-State-Owned IMD	Hidalgo	16%
Non-State-Owned IMD	Lubbock	0%
Non-State-Owned IMD	MRSA Central	64%
Non-State-Owned IMD	MRSA Northeast	0%
Non-State-Owned IMD	MRSA West	30%
Non-State-Owned IMD	Tarrant	21%
Non-State-Owned IMD	Travis	49%
Rural Hospitals	Bexar	36%
Rural Hospitals	Dallas	50%
Rural Hospitals	Harris	33%
Rural Hospitals	Hidalgo	0%
Rural Hospitals	Jefferson	10%
Rural Hospitals	Lubbock	81%
Rural Hospitals	MRSA Central	13%
Rural Hospitals	MRSA Northeast	15%
Rural Hospitals	MRSA West	15%

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

## Round 3 Question Set

July 8, 2021

Rural Hospitals	Nueces	21%
Rural Hospitals	Tarrant	14%
Rural Hospitals	Travis	23%
State-Owned IMD	Bexar	41%
State-Owned IMD	Dallas	283%
State-Owned IMD	El Paso	59%
State-Owned IMD	Harris	69%
State-Owned IMD	Hidalgo	58%
State-Owned IMD	MRSA Central	0%
State-Owned IMD	MRSA Northeast	0%
State-Owned IMD	MRSA West	65%
State-Owned IMD	Travis	168%
State-Owned Non-IMD	Bexar	2325%
State-Owned Non-IMD	Dallas	0%
State-Owned Non-IMD	Harris	66%
State-Owned Non-IMD	MRSA Northeast	62%
Urban	Bexar	59%
Urban	Dallas	58%
Urban	El Paso	32%
Urban	Harris	170%
Urban	Hidalgo	81%
Urban	Jefferson	126%
Urban	Lubbock	0%
Urban	MRSA Central	80%
Urban	MRSA Northeast	93%
Urban	MRSA West	65%
Urban	Nueces	49%
Urban	Tarrant	89%
Urban	Travis	65%

- i. Based on the information in the table above, there are certain combinations of SDA and provider classes that it appears the state would require plans to pay percentage increases that would more than double the negotiated rate (see highlighted cells in table above). For example, it appears the state would require plans to pay an increase to 170% of the negotiated rate. This would suggest that plans are negotiating notably low rates compared to Medicare. Does the state have concerns that the plans are not meeting their network adequacy and access to care requirements under the contract?

State Response: The state is proposing these rate increases as they are supported by estimates of what Medicare or average commercial payors would have paid for the same services. The state works with our managed care organizations and providers to ensure access to care and network adequacy

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

Round 3 Question Set

July 8, 2021

requirements are met. With respect to access to care, the state notes that during the initial year that UHRIP was created, the stated goal was to support and improve access to care. The state reaffirms that this program will help support beneficiaries' access to care as it has in prior years, but with the expansion and reform of UHRIP into the CHIRP program, we will also target additional quality goals and objectives.

**CMS Round 2 Question:** How does the state work with the managed care organization and provider to ensure access to care? Would the state be able to share any data that supports the state's affirmation that this SDP (or UHRIP) has helped to support and improve access to care?

**State Round 2 Response:**

In terms of how UHRIP has helped to support and improve access to care, the goal of UHRIP is to ensure access to care by preventing decreases in network adequacy. This is the stated evaluation hypothesis in the UHRIP evaluation report (see "Hypothesis 1.4. UHRIP will support an adequate MCO provider network to ensure members' access to care.").

The *Results* section of the UHRIP Evaluation Report 2018-2019 (CHIRP reprint Attachment J) also contains information about the state's Network Adequacy contract requirements. HHSC ensures that MCOs and DMOs have adequate provider networks and provide access to care. The state tracks timeliness of care through annual surveys; monitors member and provider complaints; monitors provider terminations; analyzes geo-mapping reports to measure the distance and travel time between providers' geographic locations and members' residences; and monitors utilization of out-of-network providers.

The results of the evaluation report show that network adequacy for acute care hospital providers was maintained over time, despite the limited study period for which we have data available.

- ii. In Attachment C, there is one facility – Texas DSHS TCID (NPI 1841354677) that plans would be required to pay an increase of 2325% of the negotiated rate. Can the state first confirm that this is correct and not a typo? If this is correct, this would suggest that plans are paying this facility at a rate that is just over 4% of Medicare. If this is the case, please explain how this rate is sufficient for the plans to maintain access to care requirements?

State Response: The program values have been updated based upon actual enrollment in the program and with preliminary encounter data, as shown on the "Revised Q21 Hospital Rates" tab of Attachment 1. TCID now is receiving a rate of 0%. It does not have any eligible inpatient or outpatient encounters.



TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

**Round 3 Question Set**

July 8, 2021

**CMS Round 2 Question:** This seems to be a significant update; can the state provide additional details on this update and why the original data was so off?

**State Round 2 Response:** The original data was survey data, and the state has since received new encounter data trends and actual applications. The combination of these two elements led to many changes in the program values from those that were estimated based on the initial theoretical model.

- iii. There are 8 combinations of classes and SDAs (highlighted in green above) that are reported as 0% for the UHRIP increase. Is it correct to say that these facilities are not eligible for an increase under UHRIP because they are already paid by plans at a rate that would result in no Medicare gap? Or did these facilities not apply to participate?

**State Response:** The modeling has been updated based upon actual enrollment in the program. The “Avg Increase by SDA and Class” tab of Attachment 1 shows 11 SDA and class combinations that have 0% inpatient UHRIP increase. The 11 combinations either did not have a positive Medicare gap or had \$0 in inpatient encounters. On the outpatient side, 19 SDA and class combinations have a 0% outpatient rate increase. In addition, 3 SDA and class combinations did not have any hospitals apply for the program.

**CMS Round 2 Question:** Please note, CMS will not be able to make a final determination on the state’s preprint until we receive final data. When the state provides the final data in June – can the state please differentiate in some manner for the SDA and class combinations which did not have a positive Medicare gap and which had \$0 in inpatient encounters?

**State Round 2 Response:** The SDA and class combinations that did not have a positive Medicare gap and also had \$0 in inpatient encounters are as follows:

- State-Owned IMD Harris
- State-Owned IMD MRSA Central
- State-Owned IMD MRSA Northeast
- Non-State-Owned IMD MRSA Northeast

- f. In review of the data, it appears that the ACIA increases for each class within each SDA vary by hospital – can the state confirm this is correct? Can the state also confirm that the percentage increase ranges included in the table below are correct?

**State Response:** All hospitals that participate in ACIA received a uniform percentage of the individual hospital’s calculated ACR gap less payments received in UHRIP. Due to the varying levels of average commercial reimbursement at each provider, this uniform percentage of the gap results in a varied rate increase when applied to the estimated managed care encounters. The approach ensures that expenditures were directed equally, but that payments were restricted to a reasonable level.

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

## Round 3 Question Set

July 8, 2021

The values have been updated based upon actual enrollment in the program. The “Avg Increase by SDA and Class” tab of Attachment 1 tab shows the new ACIA rates. They are determined separately for each hospital for inpatient and outpatient services. The rates below were correct at the time of the initial submission of the pre-print.

Provider Class	SDA	ACIA Percentage Increase
Children's Hospital	Bexar	30%
Children's Hospital	Dallas	0-52%
Children's Hospital	El Paso	54%
Children's Hospital	Harris	0-51%
Children's Hospital	Lubbock	100%
Children's Hospital	Nueces	67%
Children's Hospital	Tarrant	114%
Children's Hospital	Travis	188%
Non-State-Owned IMD	Bexar	0%
Non-State-Owned IMD	Dallas	0-115%
Non-State-Owned IMD	El Paso	0%
Non-State-Owned IMD	Harris	0-163%
Non-State-Owned IMD	Hidalgo	0%
Non-State-Owned IMD	Lubbock	0%
Non-State-Owned IMD	MRSA Central	0%
Non-State-Owned IMD	MRSA Northeast	0%
Non-State-Owned IMD	MRSA West	0-6%
Non-State-Owned IMD	Tarrant	0%
Non-State-Owned IMD	Travis	0-123%
Rural Hospitals	Bexar	0-55%
Rural Hospitals	Dallas	127%
Rural Hospitals	Harris	0%
Rural Hospitals	Hidalgo	0-60%
Rural Hospitals	Jefferson	0-87%
Rural Hospitals	Lubbock	0-193%
Rural Hospitals	MRSA Central	0-203%
Rural Hospitals	MRSA Northeast	0-60%
Rural Hospitals	MRSA West	0-161%
Rural Hospitals	Nueces	0-22%
Rural Hospitals	Tarrant	87-220%
Rural Hospitals	Travis	0-42%
State-Owned IMD	Bexar	0%
State-Owned IMD	Dallas	0%
State-Owned IMD	El Paso	0%
State-Owned IMD	Harris	0%
State-Owned IMD	Hidalgo	0%
State-Owned IMD	MRSA Central	0%

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

**Round 3 Question Set**

July 8, 2021

State-Owned IMD	MRSA Northeast	0%
State-Owned IMD	MRSA West	0%
State-Owned IMD	Travis	0%
State-Owned Non-IMD	Bexar	0%
State-Owned Non-IMD	Dallas	0-184%
State-Owned Non-IMD	Harris	0%
State-Owned Non-IMD	MRSA Northeast	0%
Urban	Bexar	0-153%
Urban	Dallas	0-647%
Urban	El Paso	0-246%
Urban	Harris	0-178%
Urban	Hidalgo	0-114%
Urban	Jefferson	0-70%
Urban	Lubbock	0-930%
Urban	MRSA Central	0-83%
Urban	MRSA Northeast	0-124%
Urban	MRSA West	0-183%
Urban	Nueces	0-116%
Urban	Tarrant	0-3596%
Urban	Travis	0-139%

- i. There are 365 individual facilities that are reported as 0% for the ACIA increase. Is it correct to say that these facilities are not eligible for an increase under ACIA because they are already paid by plans at a rate that would result in no ACR gap? Or did these facilities not apply to participate?

**State Response:** There are now 166 individual facilities that are reported as 0% for ACIA. Both reasons cited above resulted in facilities being reported as 0% for ACIA.

**CMS Round 2 Question:** Please note, CMS will not be able to make a final determination on the state's preprint until we receive final data. When the state provides the final provider level payment analysis, please differentiate between those facilities that are not eligible for an increase under ACIA because they are already paid by plans at a rate that would result in no ACR gap (e.g. 0%) vs. those facilities that did not apply for the ACIA portion (e.g. N/A).

**State Round 2 Response:** Column Y has been added in the "CHIRP Payment Calc" tab of Attachment C to indicate whether a facility requested participation in the ACIA component or not.

**CMS Round 3 Question:** In looking at tab "CHIRP Payment Calc" in Attachment C, in Column Y:

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

**Round 3 Question Set**

July 8, 2021

**1. What does “#N/A” mean?**

**State Round 3 Response:** This is an error that occurred because some of our providers do not yet have a TPI, an identifier that we use to index data. It is now corrected.

**2. Of the 419 hospital entries, 400 hospitals requested to participate in ACIA, 16 hospitals did not request to participate, and 3 are listed as “#N/A”. Is this an accurate summation?**

**State Round 3 Response:** After the error correction, we see that 17 hospitals did not request to participate. The 402 others requested to participate in ACIA.

- ii. There are 9 facilities that are reported as 0% UHRIP increase but are reported as having an ACIA rate increase. The 9 facilities are listed below. Does this mean that the rates negotiated by the plans result in no Medicare gap but there is still an ACR gap? Also, can the state confirm if the facilities still must meet the requirements for both UHRIP and ACIA?

**State Response:** There are now 25 facilities that have this circumstance. Yes, this usually means the rates negotiated by the plans result in no Medicare gap but there is still an ACR gap. If a provider is in this situation, it must still meet the requirements for both UHRIP and ACIA. However, the values have been updated based upon actual enrollment.

NPI	Provider Name	Class	SDA	UHRIP Rate (Component 1)	ACIA Rate (Component 2)	Total CHIRP Rate Increase
1467442418	NORTHWEST HEALTHCARE SYSTEM INC-NORTHWEST TEXAS-PSYC UNIT	Urban	Lubbock	0%	78%	78%
1447355771	SETON HEALTHCARE-DELL CHILDRENS MEDICAL CENTER	Children's	Travis	0%	188%	188%
1407191984	BSA HOSPITAL LLC-BAPTIST ST ANTHONYS HEALTH SYSTEM	Urban	Lubbock	0%	140%	140%
1437171568	METHODISTS CHILDRENS HOSPITAL-COVENANT CHILDRENS HOSPITAL	Children's	Lubbock	0%	100%	100%
1972517365	COVENANT HEALTH SYSTEM-COVENANT MEDICAL CENTER	Urban	Lubbock	0%	302%	302%

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

**Round 3 Question Set**

July 8, 2021

1285798918	UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL CENTER AT-UNIVERSITY OF TEXAS SOUTHWESTERN UNIVERSITY HOSPTI	State- Owned Non-IMD	Dallas	0%	184%	184%
1770579591	FORT DUNCAN REGIONAL MEDICAL CENTER LP-FORT DUNCAN REGIONAL MEDICAL CENTER	Rural	Hidalgo	0%	60%	60%
1912948845	PHYSICIANS SURGICAL HOSPITALS LLC-QUAIL CREEK SURGICAL HOSPITAL	Urban	Lubbock	0%	410%	410%
1013941780	COVENANT LONG TERM CARE LP-COVENANT SPECIALTY HOSPITAL	Urban	Lubbock	0%	930%	930%

**CMS Round 3 Question:** In reviewing Attachment C, there appears to be 24 facilities that have a 0% inpatient UHRIP rate but would have an ACIA rate increase, and 4 facilities that have a 0% outpatient UHRIP rate but would have an ACIA rate. Is that an accurate summation?

**State Round 3 Response:** Yes, that is the state's result as well.

- iii. There is also a number of SDA/class combinations where only some of the facilities would receive an ACIA increase but not all. Is this because only some of the facilities applied for the ACIA component and others did not? Is it that the other facilities did not have a remaining ACR gap after the UHRIP increase?

**State Response:** Both of the reasons cited above could occur, so the assumptions are correct. Please see the "Revised Q21 Hospital Rates" tab of Attachment 1 for the updated rates.

**CMS Round 2 Question:** Please note, CMS will not be able to make a final determination on the state's preprint until we receive final data. When the state provides the final provider level payment analysis, please differentiate between those facilities that are not eligible for an increase under ACIA because they are already paid by plans at a rate that would result in no ACR gap (e.g. 0%) vs. those facilities that did not apply for the ACIA portion (e.g. N/A).

**State Round 2 Response:** Column Y has been added in the "CHIRP Payment Calc" tab of Attachment C to indicate whether a facility requested participation in the ACIA component or not.

Children's Hospital	Harris	1 facility reported with ACIA increase; other 3 reported 0%
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TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

## Round 3 Question Set

July 8, 2021

Non-State-Owned IMD	Dallas	1 facility reported with ACIA increase; other 6 reported 0%
Non-State-Owned IMD	Harris	1 facility reported with ACIA increase; other 15 reported 0%
Non-State-Owned IMD	MRSA West	1 facility reported with ACIA increase; other 3 reported 0%
Non-State-Owned IMD	Travis	2 facilities reported with ACIA increase; other 5 reported 0%
Rural Hospitals	Bexar	1 facility reported with ACIA increase; other 2 reported 0%
Rural Hospitals	Hidalgo	1 facility reported with only ACIA increase; other reported no increases.
Rural Hospitals	Jefferson	2 facilities reported with ACIA increase; other 4 reported 0%
Rural Hospitals	Lubbock	2 facilities reported with ACIA increase; other 8 reported 0%
Rural Hospitals	MRSA Central	2 facilities reported with ACIA increase; other 18 reported 0%
Rural Hospitals	MRSA Northeast	13 facilities reported with ACIA increase; other 10 reported 0%
Rural Hospitals	MRSA West	15 facilities reported with ACIA increase; other 50 reported 0%
Rural Hospitals	Nueces	4 facilities reported with ACIA increase; other 2 reported 0%
Rural Hospitals	Tarrant	1 facility reported with only ACIA increase; other reported 0%.
Rural Hospitals	Travis	5 facilities reported with ACIA increase; other 1 reported 0%
State-Owned Non-IMD	Dallas	1 facility reported with only ACIA increase; other reported 0%.
Urban Hospitals	Bexar	8 facilities reported with ACIA increase; other 14 reported 0%
Urban Hospitals	Dallas	23 facilities reported with ACIA increase; other 31 reported 0%
Urban Hospitals	El Paso	5 facilities reported with ACIA increase; other 6 reported 0%
Urban Hospitals	Harris	10 facilities reported with ACIA increase; other 59 reported 0%
Urban Hospitals	Hidalgo	10 facilities reported with ACIA increase; other 9 reported 0%
Urban Hospitals	Jefferson	4 facilities reported with ACIA increase; other 6 reported 0%
Urban Hospitals	Lubbock	5 facilities reported with ACIA increase; other 6 reported 0%
Urban Hospitals	MRSA Central	7 facilities reported with ACIA increase; other 4 reported 0%
Urban Hospitals	MRSA Northeast	8 facilities reported with ACIA increase; other 12 reported 0%
Urban Hospitals	MRSA West	7 facilities reported with ACIA increase; other 8 reported 0%
Urban Hospitals	Nueces	3 facilities reported with ACIA increase; other 8 reported 0%
Urban Hospitals	Tarrant	20 facilities reported with ACIA increase; other 22 reported 0%
Urban Hospitals	Travis	13 facilities reported with ACIA increase; other 13 reported 0%

- iv. CMS' understanding is that the facilities who apply for the ACIA program must provide commercial payer data as part of the application. What is the state's process for verifying this data?

State Response: Providers must certify that the data is accurate. Providers are responsible for keeping all documentation for a period of no less than 5 years from the date of application. Providers are subject to fraud, waste, and abuse audits. If HHSC determines at any point that rates were based upon inaccurate information the providers would be subject to recoupment and potential other legal remedies available to the state.

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

**Round 3 Question Set**

July 8, 2021

**CMS Round 2 Question:** Can the state please further explain what the providers must do to certify the accuracy of the data? Does the state do any checks on the validity of the data submitted? Does the state plan to conduct any audits of the data?

**State Round 2 Response:** The state does not currently plan to conduct audits specifically focused on the information provided in the CHIRP application, however, providers are subject to oversight by the state's Office of Inspector General. If at any point the state discovers that a provider misrepresented the data submitted in the CHIRP application, the provider would be subject to all possible legal and financial remedies, including recoupment of all funds.

- g. Across both components, it appears that 196 facilities would receive an increase of over 100% of negotiated rates; 45 of these facilities would receive an increase of over 200% of negotiated rates. Does the state have any concerns with this level of increase? Does the state have any concerns about the underlying rates paid by the plans being insufficient to ensure access to care and network adequacy?

State Response: Please note that these numbers have changed since the initial submission of the pre-print based upon actual enrollment applications received for the program. Based upon actual enrollment, 169 of 412 providers would receive a rate increase that exceeds 100% of negotiated rates. Sixty-six of those providers would receive a rate increase of 200% or more.

The state is proposing these rate increases as they are supported by estimates of what Medicare or average commercial payors would have paid for the same services. The state works with our managed care organizations and providers to ensure access to care and network adequacy requirements are met. With respect to access to care, the state notes that during the initial year that UHRIP was created, the stated goal was to support and improve access to care. The state reaffirms that this program will help support beneficiaries' access to care as it has for the prior four years, but with the expansion and reform of UHRIP into CHIRP, we will also target additional quality goals and objectives.

**CMS Round 2 Question:** How does the state work with the managed care organization and provider to ensure access to care? Would the state be able to share any data that supports the state's affirmation that this SDP (or UHRIP) has helped to support and improve access to care?

**State Round 2 Response:** In terms of how UHRIP has helped to support and improve access to care, the goal of UHRIP is to ensure access to care by preventing decreases in network adequacy. This is the stated evaluation hypothesis in the UHRIP evaluation report (see "Hypothesis 1.4. UHRIP will support an adequate MCO provider network to ensure members' access to care.").

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

## Round 3 Question Set

July 8, 2021

The *Results* section of the UHRIP Evaluation Report 2018-2019 (CHIRP reprint Attachment J) also contains information about the state's Network Adequacy contract requirements. HHSC ensures that MCOs and DMOs have adequate provider networks and provide access to care. The state tracks timeliness of care through annual surveys; monitors member and provider complaints; monitors provider terminations; analyzes geo-mapping reports to measure the distance and travel time between providers' geographic locations and members' residences; and monitors utilization of out-of-network providers.

The results of the evaluation report show that network adequacy for acute care hospital providers was maintained over time, despite the limited study period for which we have data available.

- h. In particular, there are 7 facilities that would receive a total CHIRP increase of 400+% of the negotiated rate. Can the state first confirm the information provided here for these 7 is correct and there are no typos? If this is correct, this would suggest that plans are paying these facilities at rates between 2.7 - 24.4% of Medicare. If this is the case, please explain how this rate is sufficient for the plan to maintain its access to care requirements?

**State Response:** The information for the seven facilities was correct at the time of the initial submission of the pre-print and was based upon the data available at the time. However, values have been updated based upon actual enrollment in the program. The state notes that the percentage increases noted below are for a total CHIRP increase and are not necessarily a comparator to Medicare. In most cases, large percentage rate increases are driven by the ACIA component, which is indicative that the commercial insurance payors are reimbursing certain providers at a much higher rate than both Medicaid and Medicare.

As CMS is aware, Texas is home to some of the most renowned providers in the world, many of whom provide specialty services for which they may have been able to negotiate with commercial payors for a substantial payment-to-charge ratio.

NPI	Provider Name	Class	SDA	UHRIP Rate (Component 1)	ACIA Rate (Component 2)	Total CHIRP Rate Increase
1649273434	BAYLOR REGIONAL MEDICAL CENTER AT PLANO-	Urban	Dallas	58%	432%	490%
1962504340	TEXAS HEART HOSPITAL OF THE SOUTHWEST LLP- BAYLOR SCOTT &	Urban	Dallas	58%	647%	705%



TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

**Round 3 Question Set**

July 8, 2021

	WHITE THE HEART HOSPITAL PLANO					
1609855139	BAYLOR HEART AND VASCULAR CENTER	Urban	Dallas	58%	575%	633%
1912948845	PHYSICIANS SURGICAL HOSPITALS LLC-QUAIL CREEK SURGICAL HOSPITAL	Urban	Lubbock	0%	410%	410%
1013941780	COVENANT LONG TERM CARE LP-COVENANT SPECIALTY HOSPITAL	Urban	Lubbock	0%	930%	930%
1871898478	MAYHILL BEHAVIORAL HEALTH LLC-	Urban	Tarrant	89%	3596%	3684%
1841354677	Texas DSHS TCID	State-Owned Non-IMD	Bexar	2325%	0%	2325%

10. Preprint Question 23: Please provide the reimbursement rate analysis for each class in each SDA separately for the mandatory and optional payments and in total. We also request that the state provide this analysis separately for inpatient and outpatient services.

State Response: The program values have been updated based upon actual enrollment in the program. The requested payment level demonstrations are included in Attachment 1 in the “IP UHRIP Payment Levels”, “OP UHRIP Payment Levels”, “IP ACIA Payment Levels”, “OP ACIA Payment Levels”, “IP CHIRP Payment Levels”, and “OP CHIRP Payment Levels” tabs. The UHRIP tabs compare to the Medicare Upper Payment Limit, the ACIA tabs compare to the Average Commercial Reimbursement for providers expected to receive an ACIA payment, and the CHIRP tabs compare the total CHIRP payments to the Medicare UPL and ACR UPL separately and only include the providers that are expected to receive an ACIA payment. The UHRIP tabs are inclusive of all providers, but the ACIA tabs are inclusive of only those providers that have applied to participate in ACIA.

Providers who did not apply for ACIA did not supply Texas with the necessary data to calculate an ACR estimate for their encounters. As a result, including payments to these providers in the numerator when comparing to ACR estimates in the denominator that are from a more limited set would be misleading.

Texas can confirm that no provider who participates only in UHRIP will receive only payments that are based upon 100% of the aggregate Medicare UPL room for their respective class. Similarly, for providers who participate in ACIA, they will receive no more than ACR.

**CMS Round 2 Questions:**

1. Can the state clarify the statement “Texas can confirm that no provider who participates only in UHRIP will receive only payment that are based upon 100% of the aggregate

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

**Round 3 Question Set**

July 8, 2021

Medicare UPL room for their respective class.” Did the state mean to say that the state can confirm that no provider who participates only in UHRIP will receive no more than the Medicare UPL for the class and SDA? **State Round 2 Response:** Yes. The state can confirm that no provider who participates only in UHRIP will receive more than the Medicare UPL for the class and SDA.

2. Please note, CMS will not be able to make a final determination on the state’s preprint until we receive final data.

11. In previous years, the state had a minimum fee schedule requirement for rural hospital inpatient and outpatient services tied to the state plan rate. While such a preprint is no longer subject to written prior approval, can the state confirm if this minimum fee schedule requirement would still be in effect for SFY 2022?

State Response: Yes, the minimum fee schedule requirement for rural hospitals will still be in effect for SFY 2022, in accordance with state statute. As CMS knows, rural hospitals are frequently financially vulnerable, and the minimum fee schedule ensures they receive the equivalent rate to the rate they would have been paid under the state plan. The rate increases from CHIRP will be available to those who applied to incentivize quality improvements.

**SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION**

12. Will the state include the UHRIP portion of the payment in the capitation rates in a manner consistent with prior years? If not, please describe the differences in the methodology this year.

State response: Yes.

13. Please describe how the state plans to include the ACIA portion of the payment in the capitation rates in more detail.

State response: ACIA will be included in the same way as UHRIP but using the ACIA percent increases. To the extent possible, there will be an ACIA section and capitation rate component in the rate certification, separate from UHRIP.

**SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE**

General Comment: The financing of the CHIRP state directed payment appear to be financed by local units of government providing intergovernmental transfers (IGTs), funds for which are largely derived from the taxing authority of these units of government through the Local Provider Participation Fund, or LPPF. The state is attesting that the LPPF is broad-based and uniform. However, it appears that not all hospitals are being taxed under the LPPF, and it also appears that some of the units of government providing IGTs do not receive any state appropriated funds and do not have any taxing authority. The state has indicated that these units of government will be funding these through public private partnerships.

14. On CHIRP spreadsheet (Attachment E) appears to indicate that Coryell County Memorial, Decatur, Fannin County, and Uvalde County Hospital Authorities all have taxing authority, while

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

**Round 3 Question Set**

July 8, 2021

the QIPP spreadsheet (Attachment F-1) indicates that they do not have taxing authority. Please explain this discrepancy.

**State Response:** The discrepancy was an oversight and these entities should have been listed as not having taxing authority. This information has been corrected in the “Revised Q35a IGT Entities” tab of Attachment 1.

15. Related to the above, for any entities that may or may not have taxing authorities and do not receive any state appropriated funds, please describe where the funding for those IGTs will come from. We note that in some of the funding information provided under the various proposals, that some of the entities which do not have taxing authority and do not receive payments are funding a substantial IGT (\$20M or more). The state has an obligation, regardless of the IGT being voluntary or compulsory, to ensure that all federal requirements related to program financing are met.

**State Response:** The state understands and agrees that it is our responsibility to ensure that funds used in the Medicaid program are public funds in accordance with 42 C.F.R. §433.51.

The public entities referred to in the state’s response to Question 14 do have authority to utilize other public revenue instruments. For example, Fannin County Hospital Authority was created by the county commissioner’s court of Fannin County pursuant to Chapter 264, Texas Health and Safety Code. Fannin County Hospital Authority does not have taxing authority but does have authority to utilize other public revenue instruments, such as bonds, to support their public activities. The funds transferred to the state by Fannin County are public funds.

Similarly, Decatur County Hospital Authority was created by the county commissioner’s court of Decatur County pursuant to Chapter 262, Texas Health and Safety Code. Decatur County Hospital Authority does not have taxing authority but does have authority to utilize other public revenue instruments, such as bonds, to support their public activities. The funds transferred to the state by Decatur County are public funds.

**CMS Round 2 Response:** As affirmed in response to question 14, it is the state’s responsibility to ensure that funds used in the Medicaid program are public funds in accordance with 42 C.F.R. §433.51. The ability of a unit of government to issue bonds is typically defined by the government entity’s authorizing statute. We are assuming that this is the case with the hospital districts involved in this arrangement. The statute indicates that CMS “may not restrict States’ use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(a)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.” To the extent that bonds are neither state or local taxes, the state has an obligation to ensure that the transferred funds are not “derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share” as indicated in the statute. Please note, that CMS is researching this matter further and may have additional questions for the state.

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

**Round 3 Question Set**

July 8, 2021

1. CMS has concerns that to the extent that the providers or provider-related organizations are participating in the purchasing of municipal bonds, that such participation could provide the appearance of a provider-related donation, potentially requiring the state to offset the collected value of the donation from the claim for FFP. Further, the notion that bonds can be thought of as loans that investors make to local governments, then the repayment of the bonds to any provider or provider-related organization may provide the appearance of recycling. The state is obligated to ensure these funding mechanisms are consistent with the statute and implementing regulations throughout the operations of such payment programs. Has the state considered how it intends to oversee the sources of financing that will support payments under this proposal to ensure the arrangements do not now and in the future entail non bona fide provider related donations or recycling of federal funds?

**State Round 2 Response:** HHSC is not aware of any circumstances in which a provider or provider-related organization has participated in the purchasing of municipal bonds.

**CMS Round 3 Questions:**

1. Can the state affirm that there are no providers that are investing in municipal bonds that are the source of the IGT that funds this state-directed payment?

**State Round 3 Response:** The state has no information regarding the sale of municipal bonds by units of government, including the identities of purchasers of such bonds or whether those purchasers are providers participating in CHIRP.

2. Can the state please describe what safeguards are in place to ensure that providers are not investing in municipal bonds that are the source of the IGT that funds this state-directed payment back to the provider, a related entity to the provider, or other providers in the same provider class in a manner that would result in a non-bona fide provider-related donation as described by 42 CFR § 433.54?

**State Round 3 Response:** The state will notify local governmental entities of this potential concern. Additionally, the state is currently working to implement a local funds monitoring effort and will incorporate this into the risk assessment questions that that are planned as part of that effort.

2. Please affirm the understanding that approval of this funding mechanism by CMS to serve as the non-federal share would not protect the state from financial risk should the arrangements result in non-bona fide provider related donations or a recycling mechanism as our review is predicated on the issued bonds as a normal course of business and not as a means to circumvent federal financing requirements.

**State Round 2 Response:** HHSC affirms this understanding.

16. Please affirm that no payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

**Round 3 Question Set**

July 8, 2021

**State Response:** Texas affirms that payments are not made under a hold harmless provision or practice.

17. Are there any agreements, written or otherwise, regarding the LPPF among providers, counties, the state, and/or any other entities that are designed to hold taxpayers harmless for the cost of the tax as defined by 42 CFR § 433.68 (f) so that taxpayers that pay more in tax than they receive in payments are guaranteed directly or indirectly to be made whole?

**State Response:** Texas affirms that neither the state nor any unit of government imposing a mandatory payment has entered into an agreement, written or otherwise, providing for any direct or indirect guarantee to hold a provider harmless for all or any portion of a mandatory payment amount.

**CMS Round 2 Question:** Is the state aware of any agreements between or among providers designed to hold taxpayers harmless for the cost of the tax? If such agreements exist, what is the state's involvement with and policy towards them?

**State Round 2 Response:** The state has been told that some sorts of arrangements between private entities exist. The state seeks no involvement and has not been involved in any such arrangements. The state does not regulate such private arrangements because it does not have the authority to do so. HHSC is willing to discuss with CMS what form of monitoring could occur to ensure that local government involvement in these arrangements does not occur.

**CMS Round 3 Response:** CMS continues to have some concerns with the financing of the non-federal share as it relates to the LPPF. We are still evaluating the state's responses and may have additional follow-up questions at a later date.

18. Given the fact that not all hospitals are being taxed under the LPPF, how can the State say that the tax is broad-based under Sections 1903(w)(3)(B) and 32 CFR § 433.68 (c) so that the tax is imposed on all non-federal non-public providers in the permissible class located at 42 CFR § 433.56?

**State Response:** Texas does not have a state-wide health care-related tax. Certain units of local government in the state, pursuant to authorization from the Texas legislature, have implemented mandatory payments that are made to the unit of government's LPPF by all non-federal, non-public providers in the area over which the unit of government has jurisdiction, in accordance with 42 CFR 433.68(c)(2).

19. In item #12 of the CHIRP Enrollment application, the language says: *"By checking this box, I certify, as the entity that owns the hospital, that no part of any payment made under CHIRP will be used to pay a contingent fee and that the agreement with the hospital does not use a reimbursement methodology that contains any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the Medicaid program, including the hospitals' receipt of CHIRP funds."* Please elaborate on what is intended by the inclusion of this statement.

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

## Round 3 Question Set

July 8, 2021

State Response: The state has a similar requirement in its Medicaid provider enrollment agreement. Because the state is requiring information about commercial payments and charges for which the state could not obtain the data independently, we included this statement to remind providers of their responsibility under the terms of the Medicaid enrollment agreement related to third party billing entities, as we believe that this is applicable also to an application preparer or the provider in this context.

20. The CHIRP Enrollment application seems to suggest that the city/county/hospital district can choose which hospitals/types of hospitals can benefit from the IGT/supplemental payments. Item #14 in the list says: *“As a sponsoring governmental entity, which class or classes of hospitals do you wish to support through IGTs of public funds? This information will be used to calculate suggested IGT responsibilities.”* The form proceeds to list out various types of hospitals classes. Section 1902(a)(2) of the Act says that the state plan must provide “for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.” If a government entity limits which providers may benefit from an IGT, how does the state assure that any hospitals that qualify under the CHIRP program will have their underlying payments fully funded as proposed under the CHIRP program?

State Response: Texas distributes a suggested list of IGT amounts to governmental entities. In our Service Delivery Areas, we may have several governmental entities that wish to transfer IGT, and this helps us to apportion the suggestions. However, the suggestions are non-binding, and local governments may transfer whatever amount they wish at the time that IGT is collected. When IGT is collected, it is pooled for all classes in the service delivery area. Governmental entities do not limit which providers may benefit from an IGT.

21. Please describe the timing associated with the city/county/hospital district filing the CHIRP application the subsequent finalization of the associated contracts. Section 1902(a)(2) of the Social Security Act obligates the state to pay that amount regardless of the amount of IGT or other non-federal share received from other sources. Please describe what occurs in instances where the funds derived from the cities/counties/hospital districts are less than the amount the state is obligated to pay out under the approved contracts. Conversely, please describe what occurs when the funds derived from the cities/counties/hospital districts are in excess of the amount the state is obligated to pay out under the approved contracts.

State Response: The state enrolls providers in April and works to review all applications before May 1. The governmental entities typically transfer IGT in early June, but the state usually does not finalize Medicaid managed care contracts until mid-July due to the complexity of the contracting process. If the state has less IGT than the amount needed to pay the increased capitation rates that are in the approved contracts, we would be required to use state General Revenue unless local governments voluntarily transfer additional IGT to the state. If there is excess IGT collected, the state returns the unused IGT proportionally to local governments

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

**Round 3 Question Set**

July 8, 2021

based upon the way it was received and without respect to the amount that any provider was paid under the program. The reconciliation process typically occurs following the run-out period for member month adjustments that occurs in the two years following the program period.

**SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS**

22. Preprint Question 42: Please confirm that the objectives listed in the preprint also appear in the updated quality strategy.

State Response: HHSC expects CHIRP to advance DSRIP transition plan focus areas that have been incorporated into the strategy on pages 36 and 37, including primary care, health promotion and disease management, behavioral health, care coordination, and maternal health and birth outcomes.

In 2017, HHSC developed an *HHS Healthcare Quality Plan* ([link](#)) to provide a higher level view of the priorities for the Medicaid program as required by state law. The 2017 Quality Plan featured a table of goals (labeled “Priorities”) and related objectives (labeled “Desired Outcomes”) (Quality Plan, page 13). HHSC updated the goals and objectives from the 2017 Quality Plan and incorporated the goals into the 2021 Texas Managed Care Quality Strategy. Please see Attachment 3 for the updated goals and objectives.

HHSC expects to achieve these objectives over time through its current and future initiatives linked to each quality goal. Appendix C of the Quality Strategy is a matrix that maps how each current HHSC quality initiative, report, and EQRO activity aligns with and works toward achieving HHSC’s quality goals.

The CHIRP objectives submitted in the preprint (in response to question 42) were derived from the updated objectives from the Quality Plan. HHSC submits the following table as a revised response to Question 42, Table 7, of the preprint.

In addition, HHSC has updated the Evaluation Plan (see Attachment 2) to align the evaluation questions and hypotheses with the revised objectives.

**[Preprint Question 42] Table 7 – Payment Arrangement Quality Strategy Goals and Objectives**

Quality Goal	Objective
<b>a. Promoting optimal health for Texans</b> at every stage of life through prevention and by engaging individuals, families, communities, and the healthcare system to address root causes of poor health	Individuals practicing healthy behaviors yield reduced rates of tobacco use, obesity, and substance use
<b>b. Providing the right care in the right place at the right time to ensure people can easily navigate the health system</b> to receive	Reduced rate of avoidable hospital admissions and readmissions



TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

## Round 3 Question Set

July 8, 2021

timely services in the least intensive or restrictive setting appropriate	
<b>c. Keeping patients free from harm</b> by building a safer healthcare system that limits human error	Reduced rate of avoidable complications or adverse healthcare events in all care settings
<b>d. Promoting effective practices for people with chronic, complex and serious conditions</b> to improve people's quality of life and independence, reduce mortality rates, and better manage the leading drivers of health care costs	Reduced rate of avoidable hospital and emergency department visits for individuals with medical complexity, including with co-occurring behavioral health diagnoses
<b>e. Attracting and retaining high-performing Medicaid providers and other healthcare professionals</b> to participate in team based, collaborative, and coordinated care	Providers participate in learning collaboratives, sharing and applying best practices to deliver high-value care
	Reduced proportion of population reporting difficulties accessing care
	Timely and efficient exchange of health information and increased interoperability

## 23. Preprint Question 43:

- a. The state notes in Attachment H, "UHRIP includes two structure measures applicable to all participating hospitals and requires twice-yearly submission of status updates for all measures." Later in the attachment, the state says, "Hospitals are not required to implement structure measures as a condition of reporting or program participation." Can the state please clarify this distinction?

State Response: "Structure Measures" are a type of measure (as opposed to "Process Measures" and "Clinical Outcome Measures") that help provide a sense of a provider's capacity, infrastructure, and strategy for delivering evidence-based best practices for high quality care. For UHRIP, hospitals are required to report on structure measures as a condition of participation. At this time, there are not prescribed implementation or achievement requirements tied to a structure measure. Reporting on structure measures will primarily be formatted as multiple-choice selections with some qualitative questions.

- b. With respect to the UHRIP measures, we request Texas designate more concrete performance targets for each measure, using numeric percentage increases or decreases to identify the state's actual target for the measures that would achieve the SDP's goals and objectives. For measures that do not have a national benchmark such as the PPC and PPA measures, we request the state define a specific performance target other than "maintain or decrease annually".



TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

## Round 3 Question Set

July 8, 2021

It is important to acknowledge that while HHSC is committed to developing a meaningful evaluation of the success of the program, the state does anticipate that the public health emergency's impact on utilization and quality data could make year-on-year comparisons difficult or unreliable in the future.

- c. For the two UHRIP structural measures, to what extent are hospitals to-date satisfying these measures?

State Response: Structure Measure 1-HIE participation: According to the Texas Health Services Authority (THSA), there are approximately 750 hospitals in Texas and 446 hospitals in Texas are in Health Information Exchanges (59.5%). Of the 446, 244 of the hospitals participate in a regional HIE; of those hospitals 144 are in national HIEs (Carequality, Commonwell and the eHealth Exchange) as well. Another 202 hospitals are in national HIEs but not involved in a Regional HIE.

Structure Measure 2-SDA Learning Collaborative participation: Participation in regional learning collaboratives (hosted by Regional Healthcare Partnership (RHP) anchor entities) has been a requirement for DSRIP performing providers, but learning collaboratives by service delivery area (SDA) will be new collaboratives. Therefore, hospitals that were DSRIP performing providers were satisfying a similar measure in order to receive DSRIP payments, but no hospitals have been measured using this new measure.

- d. It appears that non-state owned IMDs, state-owned IMDs and rural hospitals are not eligible for several of the ACIA modules. Is that due to minimal volume from these participating hospitals, or are there other reasons why these hospital classes are not eligible for many of the ACIA modules?

State Response: The non-state owned IMDs, state-owned IMDs, and rural hospitals are eligible for one ACIA module due to both minimum volume requirements and due to the types of services these hospitals provide. The design of the ACIA modules considered the variation among the provider classes in volume of population served, population mix served, and the types of services provided by the hospital class.

The evaluation plan includes an outcome measure specific to services provided at IMDs, Follow-up after Hospitalization for Mental Illness. So, while the provider-reported data for IMDs only includes one structure measure, the structure measure is related to the outcome measure HHSC will be tracking in the evaluation. The provider-reported process measures in the rural component are measures that will be tracked through the evaluation as well.

- e. It also appears that hospitals that are not eligible for any ACIA measures based on volume are still eligible to participate in ACIA and no reporting will be required. Is this correct? If so, can the state explain its rationale for this and estimate how many

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

**Round 3 Question Set**

July 8, 2021

hospitals would be eligible for ACIA and not be required to report on any ACIA measures?

State Response: Texas identified provider-reported measures for evaluation purposes that align with the Quality Strategy. Because CHIRP is open to all hospitals in Texas that serve people enrolled in Medicaid managed care, HHSC cannot ensure that every eligible hospital participating in ACIA provide services that meet measure specification inclusion criteria. For example, there are a very small number of day surgery hospitals eligible to enroll in CHIRP that may not provide inpatient services that are measured as part of the Hospital Safety module. Texas does not currently know how many hospitals, if any, would not have any required reporting but expects the number to be very small.

- f. In the application, it states that for adult and pediatric hospital and safety outcome measures, hospitals will report a performance rate as specified for all-payer types, but that for all other outcome and process measures, hospitals must report performance rates stratified by Medicaid, uninsured and other payer-types. However, the ACIA Hospital Safety and ACIA Pediatric program components contain several different measures (C2-106 – C2-110 for ACIA Hospital Safety and C2-111 – C2-116). Please explain both what this means and why the adult and pediatric hospitals safety outcomes measures will not be stratified.

State Response:

**C2 - ACIA Hospital Safety**

- C2-106: Hospital Safety Collaborative Participation
- C2-107: Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure
- C2-108: Central Line Associated Bloodstream Infection (CLABSI) Outcome Measure
- C2-109: Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure
- C2-110: Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure

In the C2 – ACIA Hospital Safety module, there are a total of five quality measures, listed above, including one Structure Measure and four Outcome Measures. The one Structure Measure (C2-106) does not require reporting by any payer type stratification, but requires only complete reporting on the provider's capacity, infrastructure, and strategy for delivering evidence-based best practices for high quality care. The four Outcome Measures in this module (, C2-107, C2-108, C2-109, and C2-110) are specifically reported per [measure steward](#) measure specifications as hospital safety standardized infection ratios (SIR), which are not stratified by payer types.

The Standard Infection Ratio (SIR) is the primary summary measure used by the [National Healthcare Safety Network \(NHSN\)](#) to track healthcare associated infections (HAIs), including catheter-associated urinary tract infections (CAUTI) (C2-107), central line-associated bloodstream infections (CLABSI) (C2-108), Clostridioides difficile

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

**Round 3 Question Set**

July 8, 2021

infections (CDI) (C2-109), and surgical site infections (SSI) (C2-110). [In HAI data analysis](#), the SIR compares the actual number of HAIs reported to the number that would be predicted, given the standard population (i.e., NHSN baseline), adjusting for several risk factors that have been found to be significantly associated with differences in infection incidence (various facility and/or patient-level factors that contribute to HAI risk within each facility).

Therefore, for measures C2-106 through C2-110, the reported denominator is the predicted NHSN baseline for a given HAI (which is not stratified by payer type) and the reported numerator is the provider's actual observed number of given HAIs, such that the resulting calculation is reported as the SIR.

**C2 - ACIA Pediatric**

- C2-111: Hospital Safety Collaborative Participation
- C2-112: Pediatric Adverse Drug Events
- C2-113: Pediatric CLABSI
- C2-114: Pediatric CAUTI
- C2-115: Pediatric SSI
- C2-116: Engagement in Integrated Behavioral Health

In the C2 – ACIA Pediatric module, there are a total of six quality measures, including one Structure Measure, four Outcome Measures, and one Process Measure. The one Process Measure (C2-116) is reported by payer type stratification. However, the one Structure Measure (C2-111) does not require reporting by any payer type stratification and requires complete reporting on the provider's capacity, infrastructure, and strategy for delivering evidence-based best practices for high quality care. The four Outcome Measures in this module (C2-112, C2-113, C2-114, and C2-115) are specifically reported as pediatric hospital safety infection rates, and per the [measure steward](#) measure specifications, these pediatric infection rates are reported by 1000 patient days, which are not stratified by payer types.

**24. Preprint Question 44:**

- a. With respect to limitations to the evaluation, the state noted that "Collectively, these limitations suggest the evaluation does not have a high degree of sensitivity to detect direct outcomes associated with UHRIP. Additional data collection efforts, such as provider-reported information or investigations into the cost-effectiveness of UHRIP payments, may provide greater opportunities to examine the direct impacts of UHRIP." Please explain how the state be including these other methods going forward to improve the validity of results.

State Response: Years 1 -4 of the UHRIP program did not include any provider specific reporting. In addition, program years 1 – 4 employed an opt-out enrollment process. Year 5 of CHIRP employs an opt-in enrollment, allowing HHSC to better isolate hospitals that participate in UHRIP and specific ACIA modules. Additionally, in the evaluation plan

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

## Round 3 Question Set

July 8, 2021

for program year 5, Texas has proposed including the results of hospital specific reporting on identified structure, process, and outcome measures that align with the state's updated Quality Strategy. Where feasible, HHSC will also work with the EQRO to develop an ACIA specific attribution population which will allow the evaluation to look at trends across the state, as well as trends specific to Medicaid managed care members who had one or more encounters with an ACIA participating provider during the measurement year. HHSC will continue to explore methods of investigating the cost-effectiveness of UHRIP and ACIA as an intervention, but does not currently have a proposal to evaluate cost-effectiveness. Texas is open to CMS suggestions for methodologies to evaluate cost-effectiveness using existing managed care data and the currently proposed hospital specific reporting.

- b. Can TX confirm that the prior year results and the evaluation plan are assessing the specific impact of this particular payment arrangement (as opposed to, say, the entirety of the state's 1115 demo)?

State Response: It is difficult to assess the specific impact of UHRIP for three main reasons: 1) Hospitals in UHRIP participated in other programs (e.g., the UC pool), and impacts of different initiatives cannot be separated; 2) UHRIP did not require any provider-reported measures, so the evaluation leveraged data produced through the EQRO for Medicaid managed care monitoring purposes. These data were not developed with UHRIP in mind, and therefore are not specifically targeted to hospital clients (e.g., CAHPS). Moving forward, the CHIRP evaluation will include provider-level reporting, which will enable the evaluation to focus more specifically on CHIRP-related measures. However, it will still be difficult to isolate the effect of CHIRP from the other initiatives simultaneously implemented across the state; 3) Because UHRIP enrollment was structured as an opt-out program and all eligible hospitals within an SDA participated, there is not an available comparison group to isolate the performance of UHRIP hospitals as compared to non-UHRIP hospitals.

- c. The CHIRP Evaluation Plan (Attachment I) indicates that, *"The primary unit of analysis for CHIRP evaluation measures will be the Medicaid member and the CHIRP evaluation population will consist of all STAR and STAR+PLUS members, including those members who may not have had an encounter with a CHIRP hospital during the study timeframe."* Why is the evaluation including members without a CHIRP hospital encounter?

State Response: Medicaid member-level data and CAHPS® Survey data (data sources for Evaluation Questions 2 and 4) are taken from EQRO reports. CAHPS Survey data and some Medicaid member-level data like PPAs measured by the EQRO cannot be attributed to an encounter with a CHIRP provider.

- d. Under the "Anticipated Limitations" section in the CHIRP Evaluation Plan (Attachment I), the state says, *"The most salient threat to the internal validity of the evaluation is the possibility that factors external to the CHIRP program will influence the evaluation"*

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

## Round 3 Question Set

July 8, 2021

*measures. For example, several additional directed payment programs (e.g., the Comprehensive Hospital Increase Reimbursement Program and Rural Access to Primary and Preventive Services) will be implemented at the same time as CHIRP".* For the underlined, did the state intend to reference the TIPPS program, and not CHIRP?

State Response: Yes, the reference to CHIRP was a typo. It should read TIPPS, not CHIRP. This change is reflected in Attachment 2.

- e. In the CHIRP Evaluation Plan (Attachment I), can the state please clarify if all measures that will be collected for the ACIA modules are captured in the evaluation plan?

State Response: No, providers will submit data for some measures that will not be included in the evaluation plan. However, all measures in the ACIA modules relate to the evaluation plan measures. See table below.

CHIRP Measure ID	CHIRP Program Measure Name	Evaluation Measure Name
C2-103	AIM Collaborative Participation	Pregnancy Associated Outcome Measure: Severe Maternal Morbidity (SMM Among All Deliveries) * Cesarean Sections among uncomplicated deliveries (IQI 21)
C2-104	Severe Maternal Morbidity	Pregnancy Associated Outcome Measure: Severe Maternal Morbidity (SMM Among All Deliveries) * Potentially Preventable Complications (PPC)*
C2-105	PC-02 Cesarean Section	Cesarean Sections among uncomplicated deliveries (IQI 21)
C2-106	Hospital Safety Collaborative Participation	Potentially Preventable Complications (PPC)*
C2-107	Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure	Potentially Preventable Complications (PPC)*
C2-108	Central Line Associated Bloodstream Infection (CLABSI) Outcome Measure	Potentially Preventable Complications (PPC)*
C2-109	Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	Potentially Preventable Complications (PPC)*
C2-110	Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	Potentially Preventable Complications (PPC)*
C2-111	Hospital Safety Collaborative Participation	Potentially Preventable Complications (PPC)*
C2-112	Pediatric Adverse Drug Events	Potentially Preventable Complications (PPC)*
C2-113	Pediatric CLABSI	Potentially Preventable Complications (PPC)*
C2-114	Pediatric CAUTI	Potentially Preventable Complications (PPC)*
C2-115	Pediatric SSI	Potentially Preventable Complications (PPC)*
C2-116	Engagement in Integrated Behavioral Health	Follow-Up After ED Visits for Mental Illness (FUM)
C2-117	Written transition procedures that include formal MCO relationship or	Follow-Up After Hospitalization for Mental Illness (FUH)*

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

## Round 3 Question Set

July 8, 2021

	EDEN notification/ADT Feed for psychiatric patients	Potentially Preventable Readmissions (PPR)
C2-118	Written transition procedures that include formal MCO relationship or EDEN notification/ADT Feed for non-psychiatric patients	Potentially Preventable Readmissions (PPR)
C2-119	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
C2-120	Preventive Care and Screening: Influenza Immunization	Preventive Care and Screening: Influenza Immunization

\*signifies measures that will be evaluated across other proposed DPPs

- f. Regarding the state's evaluation findings from previous years of the UHRIP program, we have the following comments for each of the metrics identified in Attachment J, the UHRIP evaluation report:

Measure Name	Performance Target*	CMCS Comment for state
CAHPS® Health Plan Survey : <b>Getting Needed Care - Adults</b>	<ul style="list-style-type: none"> <li>Exceed the U.S. average every year.</li> <li>Maintain or increase TX rate annually.</li> </ul>	<p>Please explain how the state will address the decline in rates in 2019.</p> <p><b>State Response:</b> The CAHPS® Health Plan survey estimates are derived from random samples of Medicaid members. Accordingly, differences in rates over time may reflect random variation in annual samples, rather than meaningful differences in the population. The 95% confidence intervals (Figure 1 shown below) indicate that the 2019 estimate is not statistically different from the 2018 estimate (i.e., the confidence intervals overlap).</p>
CAHPS® Health Plan Survey: <b>Getting Needed Care - Children</b>		<p>Please choose a performance target that is above the baseline rate (the baseline rate was 9% above the national benchmark in pre-implementation period). For this measure, please note in subsequent evaluations whether the outcomes met this performance target.</p> <p><b>State Response:</b> See performance targets in the revised Evaluation Plan (Attachment 2).</p>
CAHPS® Health Plan Survey: <b>Getting Care Quickly - Adults</b>	<ul style="list-style-type: none"> <li>Exceed the U.S. average every year.</li> <li>Maintain or increase TX rate annually.</li> </ul>	<p>Please explain how the state will address the decline in rates between the pre- and post-implementation periods.</p> <p><b>State Response:</b> The CAHPS® Health Plan survey estimates are derived from random samples of</p>

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

## Round 3 Question Set

July 8, 2021

		<p>Medicaid members. Accordingly, differences in rates over time may reflect random variation in annual samples, rather than meaningful differences in the population. The 95% confidence intervals (Figure 2 shown below) indicate that the post-implementation estimates are not statistically different than the pre-implementation estimates (i.e., the confidence intervals overlap).</p>
<p>CAHPS® Health Plan Survey: <b>Getting Care Quickly - Children</b></p>		<p>We noticed that the national benchmark was only 1% above the 2016 pre-implementation period rate and was below the 2017 rate. Please choose a performance target that is specific to the state and reflects the states goals and objectives around this metric.</p> <p>State Response: See performance targets in the revised Evaluation Plan (Attachment 2).</p>
<p><b>3M Potentially Preventable Admissions – STAR MCO</b></p>	<p>Maintain or decrease rate annually.</p>	<p>It is encouraging to see the decline in PPA but we request the state designate a specific performance target for this measures.</p> <p>State Response: See performance targets in the revised Evaluation Plan (Attachment 2).</p>
<p><b>3M Potentially Preventable Admissions – STAR+PLUS MCO Measure</b></p>	<p>Maintain or decrease rate annually.</p>	<p>Please explain what the state is doing to address the rise in PPACs relative to baseline.</p> <p>State Response: PPAs are included in the CHIRP evaluation to monitor against potential negative impacts on preventable admissions. In addition to adding structure measures of care coordination practices, and preventive care measures for rural hospitals, Texas has proposed additional directed payment programs aimed at reducing the rate of PPAs through primary and preventive care.</p>
<p><b>3M Potentially Preventable Complications – STAR MCO Measure</b></p>	<p>Maintain or decrease rate annually.</p>	<p>Please explain what the state is doing to address the rise in PPCs relative to baseline.</p> <p>State Response: Texas has added specific hospital safety reporting requirements to the ACIA module of the CHIRP program, including measures related</p>

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

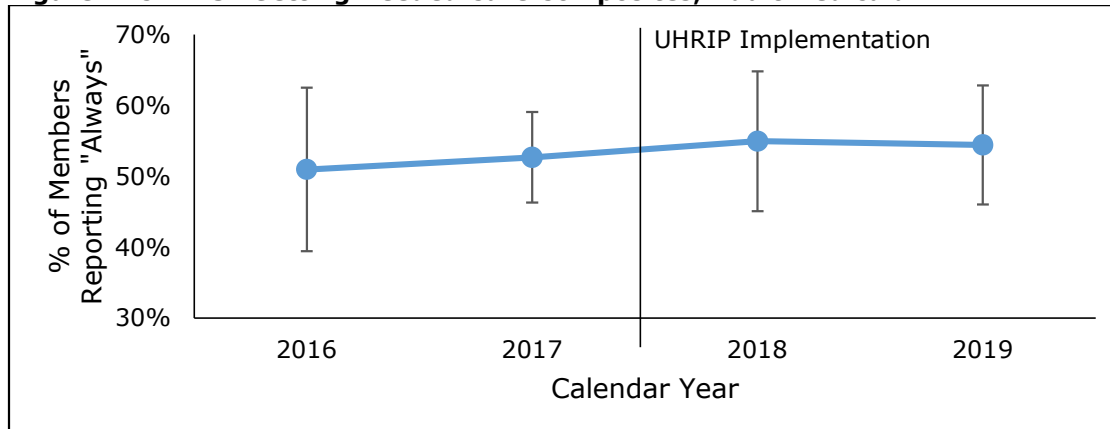
## Round 3 Question Set

July 8, 2021

		<p>to C.DIFF, sepsis, and obstetric complications which are among the leading causes of PPCs in the STAR population, as well as structure measures related to the participation in learning collaboratives that address hospital practices surrounding patient safety.</p> <p>HHSC provides strong incentives for both MCOs and hospitals to reduce potentially preventable events (PPEs). HHSC administers the Hospital Quality Based Payment (HQB) Program for all hospitals in Medicaid and CHIP in both the managed care and FFS delivery systems. Hospitals are measured on their performance for risk-adjusted rates of potentially preventable hospital readmissions within 15 days of discharge (PPR) and potentially preventable inpatient hospital complications (PPC). Hospitals can experience reductions to their payments for inpatient stays, (including their UHRIP rate enhancement payments): up to two percent for high rates of PPRs and 2.5 percent for PPCs.</p>
<b>3M Potentially Preventable Complications – STAR+PLUS MCO Measure</b>	Maintain or decrease rate annually.	<p>Please identify a performance target that demonstrates improvement based on the intervention.</p> <p>State Response: See performance targets in the revised Evaluation Plan (Attachment 2).</p>

\* As noted by the state on May 20, 2020 in 438.6(c) Attachment D Proposal D – UHRIP state response 20-21.

**Figure 1. CAHPS® Getting Needed Care Composites, Adult Medicaid**



Population: Adult Medicaid (18-64 years old) Statewide. Dual eligible members were excluded.



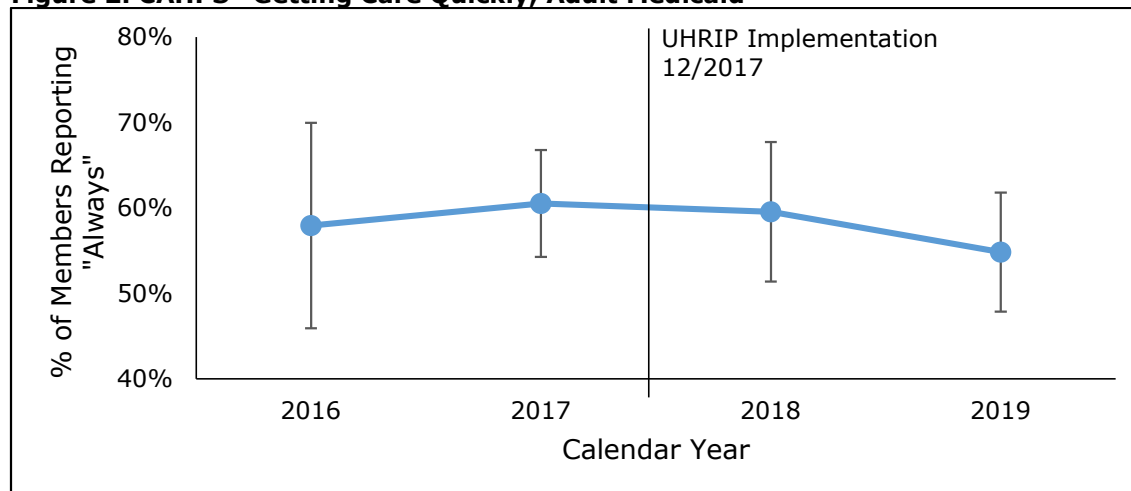
TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

**Round 3 Question Set**

July 8, 2021

Texas CAHPS® Sources: 2016 Adult Core Measures Survey; 2016 STAR Member Survey; 2016 STAR+PLUS Member Survey; 2017 Adult Core Measures Survey; 2018 STAR Adult Biennial Survey; 2018 STAR+PLUS Biennial Survey; 2018 Adult Medicaid Core Measure Survey.

Prepared by: ICHP, The University of Florida; Center for Analytics and Decision Support, HHSC.

**Figure 2. CAHPS® Getting Care Quickly, Adult Medicaid**

Population: Adult Medicaid (18-64 years old) Statewide. Dual eligible members were excluded. Texas CAHPS® Sources: 2016 Adult Core Measures Survey; 2016 STAR Member Survey; 2016 STAR+PLUS Member Survey; 2017 Adult Core Measures Survey; 2018 STAR Adult Biennial Survey; 2018 STAR+PLUS Biennial Survey; 2018 Adult Medicaid Core Measure Survey.

Prepared by: ICHP, The University of Florida; Center for Analytics and Decision Support, HHSC.

**CMS Round 2 Questions:****1. Performance Targets:**

For the PPA measure, the performance target for STAR is not an improvement target.

Additionally, it appears the performance target for STAR+ is close (0.02) to the baseline. Please provide an explanation for how/why these targets were chosen.

Measure Name	NQF#	Measure Steward	Baseline Statistic STAR	Baseline Statistic STAR+PLUS	Performance Target
Potentially Preventable Admissions (PPA)*	NA	3M	2017: 0.31 weights per 1,000 member months	2017: 9.32 weights per 1,000 member months	<ul style="list-style-type: none"> <li>Targets:               <ul style="list-style-type: none"> <li>○ STAR 2022: 0.31</li> <li>○ STAR+PLUS 2022: 9.30</li> </ul> </li> </ul>

**State Round 2 Response:** The goal is to maintain the baseline rate. PPAs are included to help ensure that enhanced hospital payment is not associated with increased inpatient care volume.

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

**Round 3 Question Set**

July 8, 2021

In the UHRIP Evaluation Report (2018 – 2019) submitted with the preprint as Attachment J, HHSC explains:

“In the Texas Medicaid program, minimizing PPAs is considered primarily an MCO responsibility to be accomplished through improved access and quality with regard to outpatient care and service coordination for their members. Therefore, the PPA rate measure serves only as a sentinel, not as an indication of participating hospitals’ performance. It would be an unintended consequence if this program resulted in a sharp increase in the PPA rate.”

For the Getting Care Quickly measure, the adult performance target appears to be the same as the baseline. Additionally, the child performance target does not seem to be a clinically meaningful improvement. Please provide an explanation for how/why these targets were chosen.

Measure Name	NQF#	Measure Steward	Baseline Statistic STAR	Baseline Statistic STAR+PLUS	Performance Target
Getting Care Quickly*	NA	NCQA	Medicaid Adult 2017: 60.5% Medicaid Child 2017: 82.9%		<ul style="list-style-type: none"> <li>• Targets:               <ul style="list-style-type: none"> <li>○ Adult 2022: 60.5%</li> <li>○ Child 2022: 83.0%</li> </ul> </li> </ul>

**State Round 2 Response:** The state target is to maintain or increase annually the percentage of Medicaid beneficiaries who reported getting care quickly relative to national trends (see original preprint Attachment I, Evaluation Plan). State performance has equaled or exceeded the national rate every year, except the adult rate in 2019. The HHSC target by 2022 is to return to, at least, the baseline rates. This approach recognizes that the potential impact of COVID-19 on this measure is not yet known.

2. Evaluation Population:

The state indicates in Attachment 2 that:

*“The primary unit of analysis for CHIRP evaluation measures will be the Medicaid member and the CHIRP evaluation population will consist of all STAR and STAR+PLUS members, including those members who may not have had an encounter with a CHIRP hospital during the study timeframe..”*

Will the hospital-level data that will be reported be limited to STAR and STAR+PLUS managed care members?

**State Round 2 Response:** The hospital-level data that will be reported are not limited to STAR and STAR+PLUS managed care members. Hospital-reported performance rates for outcome and process measures are stratified by Medicaid (including FFS and Medicaid managed care)

TX\_Fee\_IPH.OPH.BHI\_New\_20210901-20220831 (CHIRP)

**Round 3 Question Set**

July 8, 2021

because some participating providers indicated there are challenges in the connectivity of their Electronic Health Record systems and claims/billing systems to stratify by managed care only for calendar year 2021. Moreover, as clarified in Question 23.f. above, for certain hospital safety outcome measures, hospitals will specifically report performance rates by all-payer type.

*“Where feasible, the CHIRP evaluation measures will also use provider-reported data for analysis at the hospital level to supplement MMC member data.”*

Please confirm whether this hospital-level data is limited to Medicaid managed care members?

**State Round 2 Response:** The hospital-level data that will be reported are not limited to STAR and STAR+PLUS managed care members. Hospital-reported performance rates for outcome and process measures are stratified by Medicaid (including FFS and Medicaid managed care) because some participating providers indicated there are challenges in the connectivity of their Electronic Health Record systems and claims/billing systems to stratify by managed care only for calendar year 2021. Moreover, as clarified in Question 23.f. above, for certain hospital safety outcome measures, hospitals will specifically report performance rates by all-payer type.

**CMS Rnd 3 Response:** We continue to have concerns about the state’s evaluation data. We are continuing to evaluate the state’s responses and may have additional questions at a later date.

3. Evaluation Findings:

When the state submits its next preprint with the evaluation findings, please include additional context on the state’s payment and QI initiatives. The state acknowledges that they cannot isolate the impact of this SDP versus other SDPs, 1115 waiver programs, and QI programs in the state. Since other programs could be impacting the evaluation results, we would like to see a more complete policy picture to better understand the data.

**State Round 2 Response:** The state will include narrative information on other Directed Payment Programs and Quality Improvement initiatives in the evaluation findings submitted with the next preprint.

Total Dollars

	SFY 2022 FMAP	UHRIP	ACIA	Fees (Risk Margin, Admin, and Premium Tax)	Total
<b>Total</b>	<b>100%</b>	<b>\$ 2,453,658,305</b>	<b>\$ 2,274,647,616</b>	<b>\$ 291,892,432</b>	<b>\$ 5,020,198,353</b>
Federal Share	62.95%	\$ 1,544,577,903	\$ 1,431,890,674	\$ 183,746,286	\$ 3,160,214,863
Non-Federal Share	37.05%	\$ 909,080,402	\$ 842,756,942	\$ 108,146,146	\$ 1,859,983,490

## Average Rate Increase Per Claim by SDA and Class

Class and SDA	Class	SDA	Average Inpatient UHRIP Rate Increase	Average Outpatient UHRIP Rate Increase	Average Inpatient ACIA Rate Increase	Average Outpatient ACIA Rate Increase	Average Inpatient CHIRP Increase	Average Outpatient CHIRP Increase
Children's Bexar	Children's	Bexar	48%	52%	16%	74%	64%	126%
Children's Dallas	Children's	Dallas	59%	0%	45%	33%	82%	33%
Children's El Paso	Children's	El Paso	11%	129%	37%	131%	48%	260%
Children's Harris	Children's	Harris	31%	1%	38%	28%	69%	29%
Children's Lubbock	Children's	Lubbock	0%	55%	53%	125%	53%	180%
Children's Nueces	Children's	Nueces	30%	11%	112%	19%	142%	30%
Children's Tarrant	Children's	Tarrant	10%	14%	121%	44%	131%	58%
Children's Travis	Children's	Travis	0%	41%	148%	121%	148%	162%
Non-State-Owned IMD Bexar	Non-State-Owned IMD	Bexar	9%	0%	2%	Not Participating	10%	0%
Non-State-Owned IMD Dallas	Non-State-Owned IMD	Dallas	32%	0%	48%	Not Participating	56%	0%
Non-State-Owned IMD El Paso	Non-State-Owned IMD	El Paso	13%	0%	7%	Not Participating	17%	0%
Non-State-Owned IMD Harris	Non-State-Owned IMD	Harris	22%	0%	25%	Not Participating	31%	0%
Non-State-Owned IMD Hidalgo	Non-State-Owned IMD	Hidalgo	14%	0%	1%	Not Participating	15%	0%
Non-State-Owned IMD Lubbock	Non-State-Owned IMD	Lubbock	0%	0%	Not Participating	Not Participating	0%	0%
Non-State-Owned IMD MRSA Central	Non-State-Owned IMD	MRSA Central	59%	0%	Not Participating	Not Participating	59%	0%
Non-State-Owned IMD MRSA Northeast	Non-State-Owned IMD	MRSA Northeast	Not Participating	Not Participating	Not Participating	Not Participating	Not Participating	Not Participating
Non-State-Owned IMD MRSA West	Non-State-Owned IMD	MRSA West	23%	0%	Not Participating	Not Participating	23%	0%
Non-State-Owned IMD Tarrant	Non-State-Owned IMD	Tarrant	29%	0%	4%	Not Participating	30%	0%
Non-State-Owned IMD Travis	Non-State-Owned IMD	Travis	44%	0%	40%	Not Participating	57%	0%
Rural Bexar	Rural	Bexar	63%	18%	25%	23%	79%	41%
Rural Dallas	Rural	Dallas	26%	60%	126%	60%	152%	120%
Rural Harris	Rural	Harris	6%	46%	95%	2%	25%	46%
Rural Hidalgo	Rural	Hidalgo	0%	11%	34%	74%	17%	48%
Rural Jefferson	Rural	Jefferson	0%	25%	15%	40%	5%	45%
Rural Lubbock	Rural	Lubbock	67%	50%	73%	88%	99%	89%
Rural MRSA Central	Rural	MRSA Central	10%	12%	93%	65%	56%	64%
Rural MRSA Northeast	Rural	MRSA Northeast	0%	32%	35%	34%	19%	55%
Rural MRSA West	Rural	MRSA West	3%	21%	22%	36%	13%	38%
Rural Nueces	Rural	Nueces	19%	16%	77%	35%	58%	45%
Rural Tarrant	Rural	Tarrant	0%	71%	98%	131%	98%	202%
Rural Travis	Rural	Travis	18%	18%	29%	468%	41%	486%
State-Owned IMD Bexar	State-Owned IMD	Bexar	38%	0%	Not Participating	Not Participating	38%	0%
State-Owned IMD Dallas	State-Owned IMD	Dallas	289%	0%	Not Participating	Not Participating	289%	0%
State-Owned IMD El Paso	State-Owned IMD	El Paso	77%	0%	4%	Not Participating	81%	0%

State-Owned IMD Harris	State-Owned IMD	Harris	Not Participating	Not Participating	Not Participating	Not Participating	Not Participating	Not Participating	Not Participating
State-Owned IMD Hidalgo	State-Owned IMD	Hidalgo	7%	0%	5%	Not Participating	Not Participating	12%	0%
State-Owned IMD MRSA Central	State-Owned IMD	MRSA Central	Not Participating	Not Participating	Not Participating	Not Participating	Not Participating	Not Participating	Not Participating
State-Owned IMD MRSA Northeast	State-Owned IMD	MRSA Northeast	0%	0%	Not Participating	Not Participating	Not Participating	0%	0%
State-Owned IMD MRSA West	State-Owned IMD	MRSA West	111%	0%	Not Participating	Not Participating	Not Participating	111%	0%
State-Owned IMD Travis	State-Owned IMD	Travis	452%	0%	Not Participating	Not Participating	Not Participating	452%	0%
State-Owned Non-IMD Bexar	State-Owned Non-IMD	Bexar	0%	0%	Not Participating	Not Participating	Not Participating	0%	0%
State-Owned Non-IMD Dallas	State-Owned Non-IMD	Dallas	97%	134%	119%	Not Participating	Not Participating	216%	192%
State-Owned Non-IMD Harris	State-Owned Non-IMD	Harris	17%	40%	1%	Not Participating	Not Participating	18%	40%
State-Owned Non-IMD MRSA Northeast	State-Owned Non-IMD	MRSA Northeast	0%	54%	Not Participating	Not Participating	Not Participating	0%	54%
Urban Bexar	Urban	Bexar	49%	57%	95%	Not Participating	Not Participating	125%	86%
Urban Dallas	Urban	Dallas	68%	39%	309%	Not Participating	Not Participating	289%	248%
Urban El Paso	Urban	El Paso	11%	56%	186%	Not Participating	Not Participating	170%	104%
Urban Harris	Urban	Harris	189%	41%	90%	Not Participating	Not Participating	228%	60%
Urban Hidalgo	Urban	Hidalgo	74%	58%	51%	Not Participating	Not Participating	125%	89%
Urban Jefferson	Urban	Jefferson	84%	113%	54%	Not Participating	Not Participating	124%	127%
Urban Lubbock	Urban	Lubbock	0%	79%	144%	Not Participating	Not Participating	72%	143%
Urban MRSA Central	Urban	MRSA Central	50%	109%	59%	Not Participating	Not Participating	91%	181%
Urban MRSA Northeast	Urban	MRSA Northeast	60%	122%	135%	Not Participating	Not Participating	176%	172%
Urban MRSA West	Urban	MRSA West	40%	93%	134%	Not Participating	Not Participating	114%	136%
Urban Nueces	Urban	Nueces	30%	81%	64%	Not Participating	Not Participating	94%	114%
Urban Tarrant	Urban	Tarrant	77%	66%	138%	Not Participating	Not Participating	172%	108%
Urban Travis	Urban	Travis	40%	120%	116%	Not Participating	Not Participating	131%	137%

## Inpatient UHRIP Payment Levels

Class and SDA	Class	SDA	Inpatient Medicare UPL	Inpatient Medicare Base Payments	Inpatient Medicaid Through Payments	Inpatient Pass-Through Payments	Inpatient SDPs: Estimated Inpatient UHRIP Payments	Inpatient Other SDPs	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)	Number of Hospitals
Urban Dallas	Urban	1,343,753.73	1,343,753.73	\$ 1,343,753.73	\$ 1,343,753.73	\$ 1,343,753.73	1,343,753.73	-	100%	0%	0%	0%	100%	44
Urban Dallas	Urban	383,121.189	383,121.189	\$ 383,121.19	\$ 383,121.19	\$ 383,121.19	383,121.19	-	100%	0%	0%	0%	100%	35
Urban Bexar	Urban	348,745.735	348,745.735	\$ 348,745.74	\$ 348,745.74	\$ 348,745.74	348,745.74	-	100%	0%	0%	0%	100%	10
Children's Harris	Children's	257,109.281	257,109.281	\$ 257,109.28	\$ 257,109.28	\$ 257,109.28	257,109.28	-	100%	0%	0%	0%	100%	1
State-Owned Non-IMD Harris	State-Owned Non-IMD	92,300.078	92,300.078	\$ 92,300.08	\$ 92,300.08	\$ 92,300.08	92,300.08	-	100%	0%	0%	0%	100%	1
Urban MRSA Central	Urban	1,116,743.212	1,116,743.212	\$ 1,116,743.21	\$ 1,116,743.21	\$ 1,116,743.21	1,116,743.21	-	100%	0%	0%	0%	100%	10
Urban MRSA Central	Urban	315,621.436	315,621.436	\$ 315,621.44	\$ 315,621.44	\$ 315,621.44	315,621.44	-	100%	0%	0%	0%	100%	14
Children's Dallas	Children's	255,621.436	255,621.436	\$ 255,621.44	\$ 255,621.44	\$ 255,621.44	255,621.44	-	100%	0%	0%	0%	100%	4
Urban Tarrant	Urban	228,540.008	228,540.008	\$ 228,540.01	\$ 228,540.01	\$ 228,540.01	228,540.01	-	100%	0%	0%	0%	100%	32
Children's Tarrant	Children's	139,941.203	139,941.203	\$ 139,941.20	\$ 139,941.20	\$ 139,941.20	139,941.20	-	100%	0%	0%	0%	100%	1
Urban Lubbock	Urban	75,290.582	75,290.582	\$ 75,290.58	\$ 75,290.58	\$ 75,290.58	75,290.58	-	100%	0%	0%	0%	100%	10
Urban Nuces	Urban	78,852.456	78,852.456	\$ 78,852.46	\$ 78,852.46	\$ 78,852.46	78,852.46	-	100%	0%	0%	0%	100%	1
Urban El Paso	Urban	84,925.501	84,925.501	\$ 84,925.50	\$ 84,925.50	\$ 84,925.50	84,925.50	-	100%	0%	0%	0%	100%	7
Children's El Paso	Children's	1,652,709.998	1,652,709.998	\$ 1,652,709.99	\$ 1,652,709.99	\$ 1,652,709.99	1,652,709.99	-	100%	0%	0%	0%	100%	17
Children's Nuces	Children's	90,187.557	90,187.557	\$ 90,187.56	\$ 90,187.56	\$ 90,187.56	90,187.56	-	100%	0%	0%	0%	100%	14
Urban MRSA Northeast	Urban	81,353.127	81,353.127	\$ 81,353.13	\$ 81,353.13	\$ 81,353.13	81,353.13	-	100%	0%	0%	0%	100%	9
Urban MRSA West	Urban	85,853.775	85,853.775	\$ 85,853.78	\$ 85,853.78	\$ 85,853.78	85,853.78	-	100%	0%	0%	0%	100%	1
Children's Bexar	Children's	41,514.677	41,514.677	\$ 41,514.68	\$ 41,514.68	\$ 41,514.68	41,514.68	-	100%	0%	0%	0%	100%	1
Children's Travis	Children's	39,496.314	39,496.314	\$ 39,496.31	\$ 39,496.31	\$ 39,496.31	39,496.31	-	100%	0%	0%	0%	100%	4
Urban Jefferson	Urban	19,689.508	19,689.508	\$ 19,689.51	\$ 19,689.51	\$ 19,689.51	19,689.51	-	100%	0%	0%	0%	100%	1
Urban Lubbock	Urban	13,684.832	13,684.832	\$ 13,684.83	\$ 13,684.83	\$ 13,684.83	13,684.83	-	100%	0%	0%	0%	100%	1
Children's El Paso	Children's	2,326,572.24	2,326,572.24	\$ 2,326,572.24	\$ 2,326,572.24	\$ 2,326,572.24	2,326,572.24	-	100%	0%	0%	0%	100%	1
State-Owned Non-IMD Dallas	State-Owned Non-IMD	20,733.008	20,733.008	\$ 20,733.01	\$ 20,733.01	\$ 20,733.01	20,733.01	-	100%	0%	0%	0%	100%	1
State-Owned Non-IMD MRSA Northeast	State-Owned Non-IMD	268,259	268,259	\$ 268,259	\$ 268,259	\$ 268,259	268,259	-	100%	0%	0%	0%	100%	1
Rural Hidalgo	Rural	4,017.514	4,017.514	\$ 4,017.51	\$ 4,017.51	\$ 4,017.51	4,017.51	-	100%	0%	0%	0%	100%	2
Rural El Paso	Rural	3,553.960	3,553.960	\$ 3,553.96	\$ 3,553.96	\$ 3,553.96	3,553.96	-	100%	0%	0%	0%	100%	2
Rural MRSA West	Rural	2,481.631	2,481.631	\$ 2,481.63	\$ 2,481.63	\$ 2,481.63	2,481.63	-	100%	0%	0%	0%	100%	62
Rural Tarrant	Rural	5,224.029	5,224.029	\$ 5,224.03	\$ 5,224.03	\$ 5,224.03	5,224.03	-	100%	0%	0%	0%	100%	2
Non-State-Owned IMD	Non-State-Owned IMD	6,925.452	6,925.452	\$ 6,925.45	\$ 6,925.45	\$ 6,925.45	6,925.45	-	100%	0%	0%	0%	100%	6
Non-State-Owned IMD Harris	Non-State-Owned IMD	23,087.984	23,087.984	\$ 23,087.98	\$ 23,087.98	\$ 23,087.98	23,087.98	-	100%	0%	0%	0%	100%	8
Non-State-Owned IMD El Paso	Non-State-Owned IMD	3,219.281	3,219.281	\$ 3,219.28	\$ 3,219.28	\$ 3,219.28	3,219.28	-	100%	0%	0%	0%	100%	2
Non-State-Owned IMD Dallas	Non-State-Owned IMD	4,882.784	4,882.784	\$ 4,882.78	\$ 4,882.78	\$ 4,882.78	4,882.78	-	100%	0%	0%	0%	100%	3
Non-State-Owned IMD Bexar	Non-State-Owned IMD	12,176.324	12,176.324	\$ 12,176.32	\$ 12,176.32	\$ 12,176.32	12,176.32	-	100%	0%	0%	0%	100%	4
Non-State-Owned IMD MRSA West	Non-State-Owned IMD	2,597.049	2,597.049	\$ 2,597.05	\$ 2,597.05	\$ 2,597.05	2,597.05	-	100%	0%	0%	0%	100%	4
Rural Jefferson	Rural	3,764.131	3,764.131	\$ 3,764.13	\$ 3,764.13	\$ 3,764.13	3,764.13	-	100%	0%	0%	0%	100%	6
Rural Dallas	Rural	2,779.673	2,779.673	\$ 2,779.67	\$ 2,779.67	\$ 2,779.67	2,779.67	-	100%	0%	0%	0%	100%	1
Rural Nuces	Rural	7,210.580	7,210.580	\$ 7,210.58	\$ 7,210.58	\$ 7,210.58	7,210.58	-	100%	0%	0%	0%	100%	6
Rural Travis	Rural	3,093.505	3,093.505	\$ 3,093.51	\$ 3,093.51	\$ 3,093.51	3,093.51	-	100%	0%	0%	0%	100%	5
Rural Bexar	Rural	2,821.975	2,821.975	\$ 2,821.98	\$ 2,821.98	\$ 2,821.98	2,821.98	-	100%	0%	0%	0%	100%	3
Rural Lubbock	Rural	8,925.826	8,925.826	\$ 8,925.83	\$ 8,925.83	\$ 8,925.83	8,925.83	-	100%	0%	0%	0%	100%	9
Non-State-Owned IMD Travis	Non-State-Owned IMD	6,424.645	6,424.645	\$ 6,424.65	\$ 6,424.65	\$ 6,424.65	6,424.65	-	100%	0%	0%	0%	100%	6
Non-State-Owned IMD Hidalgo	Non-State-Owned IMD	2,092.010	2,092.010	\$ 2,092.01	\$ 2,092.01	\$ 2,092.01	2,092.01	-	100%	0%	0%	0%	100%	1
Rural MRSA Central	Rural	8,667.137	8,667.137	\$ 8,667.14	\$ 8,667.14	\$ 8,667.14	8,667.14	-	100%	0%	0%	0%	100%	24
Non-State-Owned IMD MRSA Central	Non-State-Owned IMD	3,134.068	3,134.068	\$ 3,134.07	\$ 3,134.07	\$ 3,134.07	3,134.07	-	100%	0%	0%	0%	100%	1
Non-State-Owned IMD Harris	Non-State-Owned IMD	4,167.807	4,167.807	\$ 4,167.81	\$ 4,167.81	\$ 4,167.81	4,167.81	-	100%	0%	0%	0%	100%	4
Non-State-Owned IMD West	Non-State-Owned IMD	508.377	508.377	\$ 508.38	\$ 508.38	\$ 508.38	508.38	-	100%	0%	0%	0%	100%	1
State-Owned IMD El Paso	State-Owned IMD	846,474	846,474	\$ 846,474	\$ 846,474	\$ 846,474	846,474	-	100%	0%	0%	0%	100%	1
State-Owned IMD Dallas	State-Owned IMD	1,013.009	1,013.009	\$ 1,013.01	\$ 1,013.01	\$ 1,013.01	1,013.01	-	100%	0%	0%	0%	100%	1
Non-State-Owned IMD	Non-State-Owned IMD	5,648	5,648	\$ 5,648	\$ 5,648	\$ 5,648	5,648	-	100%	0%	0%	0%	100%	1
State-Owned IMD Bexar	State-Owned IMD	138,576	138,576	\$ 138,576	\$ 138,576	\$ 138,576	138,576	-	100%	0%	0%	0%	100%	1
State-Owned Non-IMD Bexar	State-Owned Non-IMD	200,727	200,727	\$ 200,727	\$ 200,727	\$ 200,727	200,727	-	100%	0%	0%	0%	100%	1
State-Owned IMD Hidalgo	State-Owned IMD	692	692	\$ 692	\$ 692	\$ 692	692	-	100%	0%	0%	0%	100%	1
State-Owned IMD MRSA Central	State-Owned IMD	-	-	\$ -	\$ -	\$ -	-	-	0%	0%	0%	0%	0%	-
State-Owned IMD MRSA Northeast	State-Owned IMD	-	-	\$ -	\$ -	\$ -	-	-	0%	0%	0%	0%	0%	-
Non-State-Owned IMD MRSA Northeast	Non-State-Owned IMD	-	-	\$ -	\$ -	\$ -	-	-	0%	0%	0%	0%	0%	-

[illegible]



## Inpatient ACIA Payment Levels

Class and SDA	Class	SDA	Inpatient ACR UPL	Inpatient Medicaid Base Payments	Inpatient Pass-Through Payments	Inpatient SDPs: Estimated Inpatient ACIA Payments	Inpatient Other SDPs	Average Base Payment Level From Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)	Number of Hospitals
Urban Dallas	Urban	Dallas	\$ 182,107,858	\$ 156,727,858	\$ 46,187,320	\$ 240,692,395	\$ -	28%	34%	0%	41%	44
Urban Dallas	Urban	Dallas	\$ 211,264,357	\$ 196,727,858	\$ 46,187,320	\$ 240,692,395	\$ -	28%	34%	0%	68%	35
Urban Dallas	Urban	Dallas	\$ 502,478,113	\$ 257,109,811	\$ -	\$ 108,976,762	\$ -	51%	22%	0%	73%	1
Children's Harris	Children's	Harris	\$ 94,230,514	\$ 75,479,154	\$ -	\$ 981,287	\$ -	80%	1%	0%	81%	1
State-Owned Non-IMD Harris	State-Owned Non-IMD	Harris	\$ 182,107,858	\$ 156,727,858	\$ 46,187,320	\$ 240,692,395	\$ -	28%	34%	0%	68%	35
Urban MRSA Central	Urban	MRSA Central	\$ 3,186,728,485	\$ 45,273,753	\$ 16,845,411	\$ 34,441,897	\$ -	35%	27%	0%	75%	4
Urban MRSA Central	Urban	MRSA Central	\$ 182,107,858	\$ 156,727,858	\$ 46,187,320	\$ 240,692,395	\$ -	28%	34%	0%	68%	35
Children's Dallas	Children's	Dallas	\$ 329,695,402	\$ 147,331,838	\$ -	\$ 65,240,946	\$ -	45%	20%	0%	65%	4
Urban Tarrant	Urban	Tarrant	\$ 451,898,271	\$ 117,264,940	\$ -	\$ 156,953,346	\$ -	26%	0%	0%	61%	32
Children's Tarrant	Children's	Tarrant	\$ 349,615,567	\$ 127,701,852	\$ -	\$ 146,532,668	\$ -	37%	0%	0%	78%	1
Urban Lubbock	Urban	Lubbock	\$ 61,076,664	\$ 21,562,757	\$ -	\$ 27,604,609	\$ -	35%	45%	0%	81%	10
Urban Nueces	Urban	Nueces	\$ 128,117,880	\$ 45,273,753	\$ 16,845,411	\$ 34,441,897	\$ -	35%	27%	0%	75%	4
Urban El Paso	Urban	El Paso	\$ 3,186,728,485	\$ 45,273,753	\$ 16,845,411	\$ 34,441,897	\$ -	35%	27%	0%	75%	4
Children's Nueces	Children's	Nueces	\$ 167,850,776	\$ 59,559,097	\$ -	\$ 63,383,026	\$ -	35%	38%	0%	73%	17
Urban MRSA Northeast	Urban	MRSA Northeast	\$ 157,181,312	\$ 51,479,996	\$ -	\$ 46,807,667	\$ -	33%	0%	0%	63%	14
Urban MRSA West	Urban	MRSA West	\$ 153,616,367	\$ 43,567,042	\$ -	\$ 10,183,956	\$ -	28%	41%	0%	69%	9
Children's Bexar	Children's	Bexar	\$ 100,166,048	\$ 48,635,266	\$ -	\$ 82,494,509	\$ -	29%	49%	0%	78%	1
Children's Travis	Children's	Travis	\$ 167,452,590	\$ 18,633,451	\$ -	\$ 13,475,856	\$ -	32%	23%	0%	56%	4
Urban Jefferson	Urban	Jefferson	\$ 57,807,105	\$ 13,475,856	\$ -	\$ 13,475,856	\$ -	32%	23%	0%	56%	4
Children's Lubbock	Children's	Lubbock	\$ 13,475,856	\$ 13,475,856	\$ -	\$ 13,475,856	\$ -	32%	23%	0%	56%	4
Children's El Paso	Children's	El Paso	\$ 35,113,574	\$ 13,475,856	\$ -	\$ 13,475,856	\$ -	32%	23%	0%	56%	4
State-Owned Non-IMD Dallas	State-Owned Non-IMD	Dallas	\$ 38,211,637	\$ 10,844,748	\$ -	\$ 12,145,768	\$ -	28%	32%	0%	60%	1
State-Owned Non-IMD MRSA Northeast	State-Owned Non-IMD	MRSA Northeast	\$ -	\$ -	\$ -	\$ -	\$ -	0%	0%	0%	0%	1
Rural Hidalgo	Rural	Hidalgo	\$ 8,335,663	\$ 4,714,030	\$ -	\$ 2,557,939	\$ -	57%	31%	0%	87%	2
Urban MRSA West	Urban	MRSA West	\$ 19,592,330	\$ 28,483,355	\$ -	\$ 11,014,424	\$ -	57%	31%	0%	87%	2
Rural MRSA West	Rural	MRSA West	\$ 19,592,330	\$ 28,483,355	\$ -	\$ 11,014,424	\$ -	57%	31%	0%	87%	2
Rural Tarrant	Rural	Tarrant	\$ 16,144,463	\$ 6,813,233	\$ -	\$ 6,507,915	\$ -	42%	40%	0%	83%	2
Non-State-Owned IMD	Non-State-Owned IMD	Tarrant	\$ 1,658,232	\$ 1,210,662	\$ -	\$ 50,718	\$ -	73%	3%	0%	76%	5
Non-State-Owned IMD Harris	Non-State-Owned IMD	Harris	\$ 15,846,031	\$ 8,278,590	\$ -	\$ 3,506,627	\$ -	52%	22%	0%	74%	8
Non-State-Owned IMD El Paso	Non-State-Owned IMD	El Paso	\$ 3,519,782	\$ 2,629,931	\$ -	\$ 271,066	\$ -	75%	8%	0%	82%	2
Non-State-Owned IMD Dallas	Non-State-Owned IMD	Dallas	\$ 3,099,327	\$ 1,792,730	\$ -	\$ 445,635	\$ -	58%	14%	0%	72%	6
Non-State-Owned IMD Bexar	Non-State-Owned IMD	Bexar	\$ 4,278,219	\$ 3,818,480	\$ -	\$ 77,598	\$ -	89%	2%	0%	91%	3
State-Owned IMD MRSA West	State-Owned IMD	MRSA West	\$ 16,224	\$ 5,047	\$ -	\$ 6,764	\$ -	37%	0%	0%	37%	4
Urban MRSA West	Urban	MRSA West	\$ 16,224	\$ 5,047	\$ -	\$ 6,764	\$ -	37%	0%	0%	37%	4
Rural Jefferson	Rural	Jefferson	\$ 1,179,682	\$ 942,347	\$ -	\$ 164,366	\$ -	80%	14%	0%	94%	6
Rural Dallas	Rural	Dallas	\$ 7,939,510	\$ 2,043,025	\$ -	\$ 3,597,868	\$ -	26%	45%	0%	71%	1
Rural Nueces	Rural	Nueces	\$ 5,416,687	\$ 3,316,410	\$ -	\$ 861,619	\$ -	61%	16%	0%	77%	6
Rural Travis	Rural	Travis	\$ 3,923,819	\$ 1,952,013	\$ -	\$ 833,559	\$ -	50%	21%	0%	71%	5
Rural Bexar	Rural	Bexar	\$ 3,500,106	\$ 1,406,517	\$ -	\$ 626,495	\$ -	40%	18%	0%	58%	3
Rural Lubbock	Rural	Lubbock	\$ 4,033,107	\$ 1,576,444	\$ -	\$ 473,301	\$ -	39%	12%	0%	51%	9
Non-State-Owned IMD Travis	Non-State-Owned IMD	Travis	\$ 2,881,726	\$ 2,000,987	\$ -	\$ 68,037	\$ -	69%	2%	0%	72%	6
Non-State-Owned IMD Hidalgo	Non-State-Owned IMD	Hidalgo	\$ 2,141,394	\$ 1,781,290	\$ -	\$ 22,741	\$ -	83%	1%	0%	84%	1
Rural MRSA Central	Rural	MRSA Central	\$ 9,086,466	\$ 4,165,368	\$ -	\$ 3,084,361	\$ -	46%	34%	0%	80%	24
Non-State-Owned IMD MRSA Central	Non-State-Owned IMD	MRSA Central	\$ -	\$ -	\$ -	\$ -	\$ -	0%	0%	0%	0%	1
Non-State-Owned IMD MRSA West	Non-State-Owned IMD	MRSA West	\$ -	\$ -	\$ -	\$ -	\$ -	0%	0%	0%	0%	1
State-Owned IMD El Paso	State-Owned IMD	El Paso	\$ 523,596	\$ 320,683	\$ -	\$ 9,777	\$ -	61%	2%	0%	63%	4
State-Owned IMD Travis	State-Owned IMD	Travis	\$ -	\$ -	\$ -	\$ -	\$ -	0%	0%	0%	0%	1
State-Owned IMD Dallas	State-Owned IMD	Dallas	\$ -	\$ -	\$ -	\$ -	\$ -	0%	0%	0%	0%	1
Non-State-Owned IMD Lubbock	Non-State-Owned IMD	Lubbock	\$ -	\$ -	\$ -	\$ -	\$ -	0%	0%	0%	0%	1
State-Owned IMD Bexar	State-Owned IMD	Bexar	\$ -	\$ -	\$ -	\$ -	\$ -	0%	0%	0%	0%	1
State-Owned Non-IMD Bexar	State-Owned Non-IMD	Bexar	\$ -	\$ -	\$ -	\$ -	\$ -	0%	0%	0%	0%	1
State-Owned IMD Hidalgo	State-Owned IMD	Hidalgo	\$ 952	\$ 437	\$ -	\$ 185	\$ -	46%	19%	0%	65%	1
State-Owned IMD MRSA Central	State-Owned IMD	MRSA Central	\$ -	\$ -	\$ -	\$ -	\$ -	0%	0%	0%	0%	1
State-Owned IMD MRSA Northeast	State-Owned IMD	MRSA Northeast	\$ -	\$ -	\$ -	\$ -	\$ -	0%	0%	0%	0%	1
Non-State-Owned IMD MRSA Northeast	Non-State-Owned IMD	MRSA Northeast	\$ -	\$ -	\$ -	\$ -	\$ -	0%	0%	0%	0%	1

Class	Class and SDA	SDA	Outpatients: ACS UPL	Outpatient Medicaid Base Payments	Outpatient Pass-Through Payments	Estimated SDPs: ACA Payments	Outpatient Other SDPs	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Directed to State (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)	Number of Hospitals
Urban	Urban Dallas	Urban Dallas	\$ 189,122,894	\$ 189,122,894	\$ -	\$ -	\$ -	\$ -	32%	0%	0%	\$ 189,122,894	35
Urban	Urban Bexar	Urban Bexar	\$ 87,006,569	\$ 24,966,097	\$ -	\$ -	\$ 59,105,548	\$ -	32%	0%	0%	\$ 87,006,569	10
Urban	Urban Harris	Urban Harris	\$ 235,509,101	\$ 129,854,073	\$ -	\$ -	\$ 72,795,005	\$ -	31%	0%	0%	\$ 235,509,101	1
State-Owned Non-IMD	Urban	Urban	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	0%	0%	0%	\$ -	1
State-Owned Non-IMD	Urban	Urban	\$ 43,447,767	\$ 9,536,589	\$ -	\$ -	\$ 8,359,770	\$ -	22%	0%	0%	\$ 43,447,767	1
State-Owned Non-IMD	Urban	Urban	\$ 3,370,320	\$ 3,370,320	\$ -	\$ -	\$ -	\$ -	0%	0%	0%	\$ 3,370,320	1
State-Owned Non-IMD	Urban	Urban	\$ 214,502,409	\$ 120,448,334	\$ -	\$ -	\$ 65,427,569	\$ -	31%	0%	0%	\$ 214,502,409	4
State-Owned Non-IMD	Urban	Urban	\$ 80,369,983	\$ 22,948,691	\$ -	\$ -	\$ 20,363,987	\$ -	25%	0%	0%	\$ 80,369,983	32
State-Owned Non-IMD	Urban	Urban	\$ 117,194,431	\$ 50,301,478	\$ -	\$ -	\$ 38,328,756	\$ -	43%	0%	0%	\$ 117,194,431	1
State-Owned Non-IMD	Urban	Urban	\$ 49,510,977	\$ 9,950,346	\$ -	\$ -	\$ 16,365,393	\$ -	33%	0%	0%	\$ 49,510,977	10
State-Owned Non-IMD	Urban	Urban	\$ 32,740,763	\$ 10,082,581	\$ -	\$ -	\$ 6,025,800	\$ -	18%	0%	0%	\$ 32,740,763	4
State-Owned Non-IMD	Urban	Urban	\$ 13,170,619	\$ 3,167,643	\$ -	\$ -	\$ 1,673,819	\$ -	15%	0%	0%	\$ 13,170,619	19
State-Owned Non-IMD	Urban	Urban	\$ 41,205,833	\$ 17,070,293	\$ -	\$ -	\$ 6,210,410	\$ -	25%	0%	0%	\$ 41,205,833	19
State-Owned Non-IMD	Urban	Urban	\$ 56,414,896	\$ 27,672,674	\$ -	\$ -	\$ 14,024,075	\$ -	48%	0%	0%	\$ 56,414,896	1
State-Owned Non-IMD	Urban	Urban	\$ 75,110,401	\$ 12,923,019	\$ -	\$ -	\$ 19,150,031	\$ -	17%	0%	0%	\$ 75,110,401	14
State-Owned Non-IMD	Urban	Urban	\$ 44,880,525	\$ 7,337,753	\$ -	\$ -	\$ 14,237,486	\$ -	25%	0%	0%	\$ 44,880,525	9
State-Owned Non-IMD	Urban	Urban	\$ 51,341,877	\$ 12,042,825	\$ -	\$ -	\$ 18,422,990	\$ -	28%	0%	0%	\$ 51,341,877	1
State-Owned Non-IMD	Urban	Urban	\$ 21,027,884	\$ 2,882,140	\$ -	\$ -	\$ 9,852,510	\$ -	14%	0%	0%	\$ 21,027,884	4
State-Owned Non-IMD	Urban	Urban	\$ 26,585,834	\$ 5,047,441	\$ -	\$ -	\$ 2,700,158	\$ -	12%	0%	0%	\$ 26,585,834	1
State-Owned Non-IMD	Urban	Urban	\$ 18,820,514	\$ 2,302,898	\$ -	\$ -	\$ 1,149,078	\$ -	19%	0%	0%	\$ 18,820,514	1
State-Owned Non-IMD	Urban	Urban	\$ 6,676,411	\$ 2,302,898	\$ -	\$ -	\$ 8,826,025	\$ -	12%	0%	0%	\$ 6,676,411	1
State-Owned Non-IMD	Urban	Urban	\$ 9,676,411	\$ 1,288,483	\$ -	\$ -	\$ 2,237,101	\$ -	13%	0%	0%	\$ 9,676,411	1
State-Owned Non-IMD	Urban	Urban	\$ 5,645,283	\$ 1,404,524	\$ -	\$ -	\$ 2,680,533	\$ -	0%	0%	0%	\$ 5,645,283	1
State-Owned Non-IMD	Urban	Urban	\$ 33,727,759	\$ 18,546,524	\$ -	\$ -	\$ 4,714,924	\$ -	25%	0%	0%	\$ 33,727,759	22
State-Owned Non-IMD	Urban	Urban	\$ 12,770,433	\$ 9,586,727	\$ -	\$ -	\$ 9,085,763	\$ -	36%	0%	0%	\$ 12,770,433	69%
State-Owned Non-IMD	Urban	Urban	\$ 2,001,929	\$ 2,001,929	\$ -	\$ -	\$ 5,387,192	\$ -	42%	0%	0%	\$ 2,001,929	58%
State-Owned Non-IMD	Urban	Urban	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	0%	0%	0%	\$ -	5
State-Owned Non-IMD	Urban	Urban	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	0%	0%	0%	\$ -	8
State-Owned Non-IMD	Urban	Urban	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	0%	0%	0%	\$ -	2
State-Owned Non-IMD	Urban	Urban	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	0%	0%	0%	\$ -	3
State-Owned Non-IMD	Urban	Urban	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	0%	0%	0%	\$ -	4
State-Owned Non-IMD													

[illegible]

[illegible]

## Approximate Rate Increase Per Claim by Class from CHIRP Summary

CHIRP Class	Component 1			Component 2			Total		
	Minimum Inpatient UHRIP Rate Increase	Average Inpatient UHRIP Rate Increase	Maximum Inpatient UHRIP Rate Increase	Minimum Inpatient ACIA Rate Increase	Average Inpatient ACIA Rate Increase	Maximum Inpatient ACIA Rate Increase	Minimum Inpatient Total CHIRP Rate Increase	Average Inpatient Total CHIRP Rate Increase	Maximum Inpatient Total CHIRP Rate Increase
Children's	0%	33%	59%	0%	56%	148%	48%	89%	148%
Rural	0%	10%	67%	0%	23%	346%	0%	33%	356%
State-Owned Non-IMD	0%	29%	97%	0%	30%	119%	0%	59%	216%
Urban	0%	83%	189%	0%	98%	1035%	0%	181%	1103%
Non-State-Owned IMD	0%	27%	59%	0%	8%	78%	0%	35%	122%
State-Owned IMD	0%	131%	452%	0%	1%	5%	0%	132%	452%

CHIRP Class	Component 1			Component 2			Total		
	Minimum Outpatient UHRIP Rate Increase	Average Outpatient UHRIP Rate Increase	Maximum Outpatient UHRIP Rate Increase	Minimum Outpatient ACIA Rate Increase	Average Outpatient ACIA Rate Increase	Maximum Outpatient ACIA Rate Increase	Minimum Outpatient Total CHIRP Rate Increase	Average Outpatient Total CHIRP Rate Increase	Maximum Outpatient Total CHIRP Rate Increase
Children's	0%	28%	129%	19%	61%	131%	26%	89%	260%
Rural	11%	24%	71%	0%	43%	2138%	11%	67%	2156%
State-Owned Non-IMD	0%	57%	134%	0%	15%	58%	0%	72%	192%
Urban	39%	69%	122%	0%	64%	2270%	39%	133%	2309%
Non-State-Owned IMD	0%	0%	0%	0%	0%	0%	0%	0%	0%
State-Owned IMD	0%	0%	0%	0%	0%	0%	0%	0%	0%

## Approximate Rate Increase Per Claim from CHIRP by Hospital

TPI	NPI	Provider Name	Class	SDA	Inpatient UHRIP Rate (Component 1)	Inpatient ACIA Rate (Component 2)	Total Inpatient CHIRP Rate Increase	Outpatient UHRIP Rate (Component 1)	Outpatient ACIA Rate (Component 2)	Total Outpatient CHIRP Rate Increase
137805107	1982666111	MEMORIAL HERMANN HOSPITAL SYSTEM-MHHS HERMANN HOSPITAL	Urban	Harris	189%	0%	189%	41%	23%	64%
127295703	1932123247	PARKLAND MEMORIAL HOSPITAL - PARKLAND MEMORIAL-REHAB UNIT	Urban	Dallas	68%	45%	113%	39%	33%	72%
094154402	1124074273	METHODIST HOSPITAL	Urban	Bexar	49%	88%	137%	57%	29%	86%
139135109	1477643690	TEXAS CHILDRENS HOSPITAL	Children's	Harris	31%	38%	69%	1%	28%	29%
136141205	1821011248	BEXAR COUNTY HOSPITAL DISTRICT-UNIVERSITY OF TEXAS MEDICAL	Urban	Bexar	49%	0%	49%	57%	0%	57%
094092602	1548226988	BRANCH AT GALVESTON	State-Owned Non-IMD	Harris	17%	1%	18%	40%	0%	40%
020834001	1730132234	MEMORIAL HERMANN HEALTH SYSTEM MHHS THE WOODLANDS HOSPITAL	Urban	Harris	189%	0%	189%	41%	26%	67%
137249208	1477516466	SCOTT AND WHITE MEMORIAL HOSPITAL-SCOTT AND WHITE MEDICAL CENTER TEMPLE	Urban	MRSA Central	50%	43%	93%	109%	0%	109%
160709501	1053317362	DAY SURGERY AT RENAISSANCE LLC-DOCTORS HOSPITAL AT	Urban	Hidalgo	74%	25%	99%	58%	0%	58%
159156201	1598744856	RENAISSANCE LTD VHS SAN ANTONIO PARTNERS LLC-BAPTIST MEDICAL CENTER	Urban	Bexar	49%	120%	169%	57%	15%	72%
138910807	1194743013	CHILDRENS MEDICAL CENTER OF DALLAS-CHILDRENS MEDICAL CENTER	Children's	Dallas	59%	44%	103%	0%	28%	28%
020943901	1689628984	COLUMBIA HOSPITAL MEDICAL CITY DALLAS, SUBSIDIARY-COLUMBIA	Urban	Dallas	68%	207%	275%	39%	72%	111%
133355104	1205900370	HOSPITAL AT MEDICAL C HARRIS COUNTY HOSPITAL DISTRICT	Urban	Harris	189%	0%	189%	41%	0%	41%
126675104	1992753222	TARRANT COUNTY HOSPITAL DISTRICT-JPS HEALTH NETWORK	Urban	Tarrant	77%	35%	112%	66%	0%	66%
112677302	1336172105	TEXAS HEALTH HARRIS METHODIST HOSPITAL FORT WORTH-MCALLEEN HOSPITALS LP-EDINBURG	Urban	Tarrant	77%	142%	219%	66%	25%	91%
094113001	1770573586	HOSPITAL REHAB	Urban	Hidalgo	74%	105%	179%	58%	53%	111%
021184901	1891765178	COOK CHILDREN'S MEDICAL CENTER-UNIVERSITY MEDICAL CENTER	Children's	Tarrant	10%	121%	131%	14%	44%	58%
137999206	1821087164	CHCA WOMANS HOSPITAL LP-THE WOMANS HOSPITAL OF TEXAS	Urban	Lubbock	0%	0%	0%	79%	88%	167%
112712802	1023065794	CHCA CLEAR LAKE LP-HCA HOUSTON HEALTHCARE CLEAR LAKE	Urban	Harris	189%	121%	310%	41%	0%	41%
121807504	1063466035	CHRISTUS SPOHN HEALTH SYSTEM COLLEGE OF MEDICINE MED	Urban	Harris	189%	2%	191%	41%	0%	41%
121775403	1689641680	CORPORATION-CHRISTUS SPOHN HOSPITAL CORPUS CHRISTI	Urban	Nueces	30%	44%	74%	81%	20%	101%
020973601	1508810573	BAY AREA HEALTHCARE GROUP, LTD-CORPUS CHRISTI MEDICAL CENTER	Urban	Nueces	30%	69%	99%	81%	28%	109%
094109802	1770536120	EL PASO HEALTHCARE SYSTEM LTD-LAS PALMAS MEDICAL CENTER	Urban	El Paso	11%	147%	158%	56%	72%	128%
094160103	1720033947	ST DAVIDS COMMUNITY HOSPITAL-ST DAVIDS MEDICAL CENTER	Urban	Travis	40%	74%	114%	120%	83%	203%
127300503	1184622847	CHI ST LUKES HEALTH BAYLOR COLLEGE OF MEDICINE MED	Urban	Harris	189%	0%	189%	41%	60%	101%
137245009	1467442418	NORTHWEST HEALTHCARE SYSTEM INC-NORTHWEST TEXAS-PSYC UNIT	Urban	Lubbock	0%	92%	92%	79%	0%	79%
132812205	1548286172	DRISCOLL CHILDRENS HOSPITAL	Children's	Nueces	30%	112%	142%	11%	19%	30%
292096901	1154618742	VHS HARLINGEN HOSPITAL COMPANY LLC-	Urban	Hidalgo	74%	97%	171%	58%	59%	117%
020817501	1174576698	CHCA BAYSHORE LP-HCA HOUSTON HEALTHCARE SOUTHEAST	Urban	Harris	189%	0%	189%	41%	0%	41%

112724302	1811942238	KINGWOOD PLAZA HOSPITAL-HCA	Urban	Harris		189%	29%	218%	41%	0%	41%
130601104	1700801909	HOUSTON HEALTHCARE KINGWOOD TENET HOSPITALS LIMITED-THE MEMORIAL CAMPUS	Urban	El Paso		11%	185%	196%	56%	54%	110%
135032405	1528027786	METHODIST HOSPITALS OF DALLAS- METHODIST DALLAS MEDICAL CENTER	Urban	Dallas		68%	103%	171%	39%	104%	143%
135225404	1164526786	SETON FAMILY OF HOSPITALS-SETON MEDICAL CENTER AUSTIN	Urban	Travis		40%	90%	130%	120%	0%	120%
112716902	1619924719	COLUMBIA RIO GRANDE HEALTHCARE LP-RIO GRANDE REGIONAL HOSPITAL	Urban	Hidalgo		74%	28%	102%	58%	12%	70%
020908201	1396779948	TEXAS HEALTH PRESBYTERIAN HOSPITAL DALLAS-TEXAS PRESBYTERIAN HOSPITAL OF DALLAS	Urban	Dallas		68%	127%	195%	39%	48%	87%
094108002	1679578439	MOTHER FRANCES HOSPITAL REGIONAL HEALTHCARE CENTER- MOTHER FRANCES HOSPITAL	Urban	MRSA Northeast		60%	40%	100%	122%	8%	130%
094216103	1629021845	ST DAVID'S HEALTHCARE PARTNERSHIP LP LLP-ST DAVID'S	Urban	Travis		40%	67%	107%	120%	13%	133%
181706601	1154361475	NORTH AUSTIN MEDICAL CENTER SAINT JOSEPH MEDICAL CENTER	Urban	Harris		189%	0%	189%	41%	10%	51%
112667403	1124092036	CHRISTUS GOOD SHEPHERD MEDICAL CENTER-CHRISTUS GOOD SHEPHERD	Urban	MRSA Northeast		60%	84%	144%	122%	108%	230%
162033801	1548232044	MEDICAL CENTER MARSHALL LAREDO MEDICAL CENTER	Urban	Hidalgo		74%	114%	188%	58%	48%	106%
193867201	1740450121	HOUSTON NORTHWEST OPERATING COMPANY LLC-HOUSTON NORTHWEST MEDICAL CENTER	Urban	Harris		189%	0%	189%	41%	36%	77%
020950401	1134172406	COLUMBIA MEDICAL CENTER OF ARLINGTON SUBSIDIARY LP-MEDICAL CENTER OF ARLINGTON	Urban	Tarrant		77%	61%	138%	66%	44%	110%
020844903	1821004151	CHRISTUS SANTA ROSA HEALTH CARE CORPORATION-CHRISTUS SANTA ROSA CHILDRENS	Children's	Bexar		48%	16%	64%	52%	74%	126%
138962907	1891882833	HILLCREST BAPTIST MEDICAL CENTER BAYLOR SCOTT AND WHITE MEDICAL CENTER HILLCREST	Urban	MRSA Central		50%	80%	130%	109%	27%	136%
388347201	1407364847	TYLER REGIONAL HOSPITAL LLC-UT HEALTH EAST TEXAS TYLER REGIONAL HOSPITAL	Urban	MRSA Northeast		60%	87%	147%	122%	67%	189%
094186602	1396731105	LAREDO REGIONAL MEDICAL CENTER LP-DOCTORS HOSPITAL OF LAREDO	Urban	Hidalgo		74%	27%	101%	58%	19%	77%
135237906	1023013448	UNITED REGIONAL HEALTHCARE CHCA CONROE LP-HCA HOUSTON	Urban	MRSA West		40%	142%	182%	93%	165%	258%
020841501	1962455816	HEALTHCARE CONROE EL PASO COUNTY HOSPITAL DISTRICT UNIVERSITY MEDICAL CENTER OF EL PASO	Urban	Harris		189%	0%	189%	41%	0%	41%
138951211	1316936990	BAYLOR UNIVERSITY MEDICAL CENTER	Urban	El Paso		11%	0%	11%	56%	3%	59%
139485012	1447250253	CHCA WEST HOUSTON LP-HCA HOUSTON HEALTHCARE WEST	Urban	Dallas		68%	281%	349%	39%	241%	280%
094187402	1275580938	VHS BROWNSVILLE HOSPITAL COMPANY LLC-VALLEY BAPTIST MEDICAL CENTER BROWNSVILLE	Urban	Harris		189%	7%	196%	41%	0%	41%
294543801	1184911877	TENET HOSPITALS LIMITED-THE HOSPITALS OF PROVIDENCE EAST CAMPUS	Urban	Hidalgo		74%	74%	148%	58%	35%	93%
196829901	1972709970	SETON FAMILY OF HOSPITALS-DELL SETON MEDICAL CENTER AT THE UNIVERSITY OF TEX	Urban	El Paso		11%	181%	192%	56%	72%	128%
137265806	1093810327	SETON HEALTHCARE-DELL CHILDRENS MEDICAL CENTER	Children's	Travis		40%	142%	182%	120%	4%	124%
186599001	1447355771		Children's	Travis		0%	148%	148%	41%	121%	162%

020947001	1043267701	COLUMBIA VALLEY HEALTHCARE SYSTEMS LP-VALLEY REGIONAL MEDICAL CENTER	Urban	Hidalgo		74%	70%	144%	58%	48%	106%
192751901	1295843787	MEMORIAL HERMANN HOSPITAL SYSTEM-MHHS NORTHEAST HOSPITAL	Urban	Harris		189%	21%	210%	41%	57%	98%
138296208	1679557888	CHRISTUS HEALTH SOUTHEAST TEXAS-CHRISTUS HOSPITAL METHODIST HOSPITAL OF DALLAS-METHODIST CHARLTON MEDICAL CENTER	Urban	Jefferson		84%	95%	179%	113%	31%	144%
126679303	1275592131	MEMORIAL HERMANN HOSPITAL SYSTEM-MHHS MEMORIAL CITY HOSPITAL	Urban	Dallas		68%	152%	220%	39%	71%	110%
020934801	1740233782	CHRISTUS SANTA ROSA HEALTH CARE CORPORATION-CHRISTUS SANTA ROSA HOSPITAL	Urban	Harris		189%	29%	218%	41%	25%	66%
020844901	1194787218	BAYLOR ALL SAINTS MEDICAL CENTER	Urban	Bexar		49%	82%	131%	57%	67%	124%
135036506	1669472387	BAYLOR SCOTT & WHITE ALL SAINTS MEDICAL CENTER FOR MISSION HOSPITAL INC-MISSION REGIONAL MEDICAL CENTER	Urban	Tarrant		77%	105%	182%	66%	61%	127%
112679902	1205833985	SAINT JOSEPH REGIONAL HEALTH CENTER	Urban	Hidalgo		74%	34%	108%	58%	0%	58%
127267603	1942294939	ECTOR COUNTY HOSPITAL DISTRICT-MEDICAL CENTER HOSPITAL	Urban	MRSA Central		50%	31%	81%	109%	82%	191%
135235306	1740273994	BSA HOSPITAL LLC-BAPTIST ST ANTHONY'S HEALTH SYSTEM	Urban	MRSA West		40%	36%	76%	93%	2%	95%
322879301	1407191984	SOUTHWEST GENERAL HOSPITAL LP-SOUTHWEST GENERAL HOSPITAL	Urban	Lubbock		0%	159%	159%	79%	59%	138%
136491104	1912906298	METHODIST WILLOWBROOK-HOUSTON METHODIST	Urban	Bexar		49%	92%	141%	57%	86%	143%
140713201	1871619254	WILLOWBROOK HOSPITAL	Urban	Harris		189%	107%	296%	41%	13%	54%
094148602	1093744187	BAPTIST HOSPITALS OF SOUTHEAST TEXAS-MEMORIAL HERMANN BAPTIST BEAUMONT HOSPITAL	Urban	Jefferson		84%	13%	97%	113%	20%	133%
112717702	1679528889	ST DAVIDS HEALTHCARE PARTNERSHIP LP LLP-SOUTH AUSTIN HOSPITAL	Urban	Travis		40%	107%	147%	120%	53%	173%
127311205	1699726406	COLUMBIA MEDICAL CENTER OF PLANO LP-MEDICAL CENTER OF PLANO	Urban	Dallas		68%	113%	181%	39%	90%	129%
112711003	1801852736	ODESSA REGIONAL HOSPITAL LP-ODESSA REGIONAL MEDICAL CENTER	Urban	MRSA West		40%	152%	192%	93%	87%	180%
391575301	1083112023	PIPELINE EAST DALLAS LLC-CITY HOSPITAL AT WHITE ROCK	Urban	Dallas		68%	0%	68%	39%	8%	47%
111829102	1093708679	PROVIDENCE HEALTH SERVICES OF WACO-PROVIDENCE HEALTHCARE NETWORK	Urban	MRSA Central		50%	56%	106%	109%	11%	120%
354178101	1720480627	CHILDRENS MEDICAL CENTER OF DALLAS-CHILDREN'S MEDICAL CENTER PLANO	Children's Urban	Dallas		59%	0%	59%	0%	26%	26%
137949705	1548387418	THE METHODIST HOSPITAL TEXAS HEALTH HUGULEY INC-TEXAS HEALTH HUGULEY FORT WORTH SOUTH	Urban	Harris		189%	169%	358%	41%	38%	79%
314080801	1033120423	TEXAS HEALTH HARRIS METHODIST HOSPITAL SOUTHWEST F-	Urban	Tarrant		77%	149%	226%	66%	0%	66%
120726804	1417980202	TEXAS HEALTH HARRIS METHODIST HOSPITAL SOUTHWEST F-	Urban	Tarrant		77%	160%	237%	66%	39%	105%
194997601	1851390967	UHS OF TEXOMA INC-REBA MCENTIRE CENTER FOR REHABILITATION	Urban	MRSA Northeast		60%	107%	167%	122%	0%	122%
110839103	1528026267	LONGVIEW MEDICAL CENTER LP-LONGVIEW REGIONAL MEDICAL CENTER	Urban	MRSA Northeast		60%	86%	146%	122%	38%	160%
135035706	1861488579	KNAPP MEDICAL CENTER	Urban	Hidalgo		74%	8%	82%	58%	21%	79%



137962006	1891789772	SAN JACINTO METHODIST HOSPITAL- HOUSTON METHODIST SAN JACINTO HOSPITAL	Urban	Harris		189%	129%	318%	41%	13%	54%
131038504	1598750721	HUNT MEMORIAL HOSPITAL DISTRICT- HUNT REGIONAL MEDICAL CENTER	Urban	Dallas		68%	19%	87%	39%	5%	44%
094118902	1851343909	VICTORIA OF TEXAS LP-DETAR HOSPITAL NAVARRO NORTH PSYCH UNIT	Urban	Nueces		30%	107%	137%	81%	84%	165%
137226005	1992707228	SHANNON MEDICAL CENTER- SHANNON W TX MEM HOSP	Urban	MRSA West		40%	224%	264%	93%	121%	214%
130614405	1174533343	TEXAS HEALTH ARLINGTON MEMORIAL HOSPITAL-	Urban	Tarrant		77%	218%	295%	66%	55%	121%
146021401	1295788735	MEMORIAL HERMANN HOSPITAL SYSTEM-MHHS SUGAR LAND HOSPITAL	Urban	Harris		189%	25%	214%	41%	25%	66%
094119702	1629089966	METROPLEX ADVENTIST HOSPITAL INC-METROPLEX HOSPITAL	Urban	MRSA Central		50%	57%	107%	109%	15%	124%
136143806	1255325817	MIDLAND COUNTY HOSPITAL DISTRICT- MIDLAND MEMORIAL HOSPITAL	Urban	MRSA West		40%	0%	40%	93%	9%	102%
127319504	1437171568	METHODISTS CHILDRENS HOSPITAL- COVENANT CHILDRENS HOSPITAL	Children's	Lubbock		0%	53%	53%	55%	125%	180%
112698903	1437102639	COLUMBIA MEDICAL CENTER OF MCKINNEY SUBSIDIARY LP-MEDICAL CENTER OF MCKINNEY	Urban	Dallas		68%	144%	212%	39%	83%	122%
204254101	1659525236	METHODIST HEALTHCARE SYSTEM OF SAN ANTONIO LTD LLP-METHODIST STONE OAK HOSPITAL	Urban	Bexar		49%	72%	121%	57%	24%	81%
127303903	1700883196	OAK BEND MEDICAL CENTER- OAKBEND MEDICAL CENTER	Urban	Harris		189%	0%	189%	41%	3%	44%
094207002	1770514077	TEXAS HEALTH PRESBYTERIAN HOSPITAL PLANO-	Urban	Dallas		68%	128%	196%	39%	45%	84%
020967802	1003883158	TEXAS HEALTH PRESBYTERIAN HOSPITAL DENTON-	Urban	Tarrant		77%	154%	231%	66%	42%	108%
020976902	1295736734	CHRISTUS HEALTH ARK LATEX-	Urban	MRSA Northeast		60%	96%	156%	122%	75%	197%
136326908	1104845015	TEXAS HEALTH HARRIS METHODIST HOSPITAL HURST-EULESS-	Urban	Tarrant		77%	157%	234%	66%	47%	113%
326725404	1265772362	SCOTT AND WHITE HOSPITAL COLLEGE STATION-BAYLOR SCOTT & WHITE MEDICAL CENTER COLLEGE STATIO	Urban	MRSA Central		50%	80%	130%	109%	0%	109%
377705401	1750819025	NORTH HOUSTON TRMC LLC-TOMBALL REGIONAL MEDICAL CENTER	Urban	Harris		189%	0%	189%	41%	0%	41%
020966001	1205018439	LAKE POINTE MEDICAL CENTER- BAYLOR SCOTT & WHITE MEDICAL CENTER LAKE POINTE	Urban	Dallas		68%	219%	287%	39%	219%	258%
146509801	1932152337	MEMORIAL HERMANN HOSPITAL SYSTEM-MHHS KATY HOSPITAL	Urban	Harris		189%	54%	243%	41%	32%	73%
209345201	1033165501	METHODIST HOSPITALS OF DALLAS- METHODIST RICHARDSON MEDICAL CENTER	Urban	Dallas		68%	315%	383%	39%	77%	116%
094193202	1659323772	COLUMBIA PLAZA MED CTR OF FT WORTH SUBSIDIARY LP-PLAZA MEDICAL CENTER OF FORT WORTH	Urban	Tarrant		77%	137%	214%	66%	124%	190%
160630301	1942208616	ST LUKES COMMUNITY HEALTH SERVICES-ST LUKES THE WOODLANDS HOSPITAL	Urban	Harris		189%	0%	189%	41%	47%	88%
281028501	1083937593	METHODIST HEALTH CENTERS- HOUSTON METHODIST WEST HOSPITAL	Urban	Harris		189%	28%	217%	41%	21%	62%
312239201	1841562709	HH KILLEEN HEALTH SYSTEM LLC- SETON MEDICAL CENTER HARKER HEIGHTS	Urban	MRSA Central		50%	66%	116%	109%	31%	140%

163925401	1861467573	THE MEDICAL CENTER OF SOUTHEAST TEXAS LP-	Urban	Jefferson		84%	53%	137%	113%	4%	117%
408600101	1972517365	COVENANT HEALTH SYSTEM - COVENANT MEDICAL CENTER	Urban	Lubbock		0%	0%	0%	79%	91%	170%
208013701	1619115383	SETON FAMILY OF HOSPITALS-SETON MEDICAL CENTER HAYS	Urban	Travis		40%	123%	163%	120%	32%	152%
291854201	1558659714	EL PASO CHILDRENS HOSPITAL-	Children's	El Paso		11%	37%	48%	129%	131%	260%
154504801	1881688976	HARLINGEN MEDICAL CENTER LP-PRIME HEALTHCARE SERVICES	Urban	Hidalgo		74%	2%	76%	58%	56%	114%
354018901	1790174860	MESQUITE LLC-DALLAS REGIONAL MEDICAL CENTER	Urban	Dallas		68%	182%	250%	39%	146%	185%
378943001	1073043592	HOUSTON PPH LLC-HCA HOUSTON HEALTHCARE MEDICAL CENTER	Urban	Harris		189%	21%	210%	41%	72%	113%
336478801	1952723967	HOUSTON METHODIST ST JOHN HOSPITAL-HOUSTON METHODIST CLEAR LAKE HOSPITAL	Urban	Harris		189%	78%	267%	41%	8%	49%
387515501	1417465824	ATHENS HOSPITAL LLC-UT HEALTH EAST TEXAS ATHENS HOSPITAL	Urban	MRSA Northeast		60%	31%	91%	122%	62%	184%
138411709	1720088123	GUADALUPE COUNTY HOSPITAL BOARD-GUADALUPE REGIONAL MEDICAL CENTER	Urban	Bexar		49%	26%	75%	57%	0%	57%
137907508	1124052162	CITIZENS MEDICAL CENTER COUNTY OF VICTORIA-CITIZENS MEDICAL CENTER	Urban	Nueces		30%	34%	64%	81%	0%	81%
158980601	1124137054	SETON FAMILY OF HOSPITALS-ASCENSION SETON NORTHWEST	Urban	Travis		40%	106%	146%	120%	0%	120%
194106401	1578780870	SETON FAMILY OF HOSPITALS-SETON MEDICAL CENTER WILLAMSON	Urban	Travis		40%	189%	229%	120%	0%	120%
175287501	1285798918	UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL CENTER AT-UNIVERSITY OF TEXAS SOUTHWESTERN UNIVERSITY HOSPITAL	State-Owned Non-IMD	Dallas		97%	119%	216%	134%	58%	192%
094219503	1497871628	METHODIST SUGAR LAND HOSPITAL-HOUSTON METHODIST SUGAR LAND HOSPITAL	Urban	Harris		189%	216%	405%	41%	68%	109%
190123303	1265568638	SCOTT AND WHITE HOSPITAL ROUND ROCK-BAYLOR SCOTT & WHITE MEDICAL CENTER - ROUND ROCK	Urban	Travis		40%	242%	282%	120%	0%	120%
298019501	1659559573	ST. LUKE'S COMMUNITY DEVELOPMENT CORPORATION-SUGAR-ST. LUKE'S SUGAR LAND HOSPITAL	Urban	Harris		189%	0%	189%	41%	16%	57%
020979302	1902857766	COLUMBIA MEDICAL CENTER OF LAS COLINAS, INC-LAS COLINAS MEDICAL CENTER	Urban	Dallas		68%	189%	257%	39%	54%	93%
020957901	1649223645	ST DAVIDS HEALTHCARE PARTNERSHIP LP LLP-ROUND ROCK MEDICAL CENTER	Urban	Travis		40%	88%	128%	120%	48%	168%
121776205	1992700983	BAYLOR MEDICAL CENTER AT IRVING-SAINTE LUKE'S AT VINTAGE	Urban	Dallas		68%	529%	597%	39%	411%	450%
339153401	1710314141	COMMUNITY HOSPITAL OF BRAZOSPORT-BRAZOSPORT REGIONAL HEALTH SYSTEM	Urban	Harris		189%	0%	189%	41%	12%	53%
112671602	1972581940	MEDICAL CENTER OF LEWISVILLE SUBSIDIARY LP-MEDICAL CENTER OF LEWISVILLE	Urban	Harris		189%	0%	189%	41%	0%	41%
094192402	1255384533	TENET HOSPITALS LIMITED-THE HOSPITALS OF PROVIDENCE SIERRA CAMPUS	Urban	Tarrant		77%	106%	183%	66%	40%	106%
133245406	1215969787	WEATHERFORD HEALTH SERVICES, LLC-	Urban	El Paso		11%	320%	331%	56%	81%	137%
385345901	1417471467	METHODIST HOSPITAL OF DALLAS-METHODIST MANSFIELD MEDICAL CENTER	Urban	Tarrant		77%	80%	157%	66%	41%	107%
186221101	1689629941		Urban	Tarrant		77%	186%	263%	66%	80%	146%

127278304	1417941295	UNIVERSITY OF TEXAS HEALTH AND SCIENCE CENTER AT TYLER	State-Owned Non-IMD	MRSA Northeast	0%	0%	0%	54%	0%	54%
111905902	1306897277	COLUMBIA MEDICAL CENTER OF DENTON SUBSIDIARY LP-DENTON REGIONAL MEDICAL CENTER	Urban	Tarrant	77%		120%	197%	69%	135%
131036903	1396778064	TEXAS HEALTH HARRIS METHODIST HOSPITAL CLEBURNE-	Urban	Tarrant	77%	77%	154%	231%	53%	119%
415580601	1447883301	CHRISTUS Santa Rosa Hospital-San Marcos	Urban	Travis	40%		0%	40%	82%	202%
207311601	1114903523	BRUM HEALTHCARE OF TEXAS LLC- WADLEY REGIONAL MEDICAL CENTER	Urban	MRSA Northeast	60%		49%	109%	0%	122%
192622201	1376662296	CEDAR PARK REGIONAL MEDICAL CENTER	Urban	Travis	40%	40%	169%	209%	0%	120%
350857401	1871911016	NORTH TEXAS - MCA, LLC-MEDICAL CENTER OF ALLIANCE	Urban	Tarrant	77%		66%	143%	43%	109%
349366001	1609275585	CHCA PEARLAND, LP-HCA HOUSTON HEALTHCARE PEARLAND	Urban	Harris	189%		33%	222%	23%	64%
135223905	1265430177	BAYLOR MEDICAL CENTER AT WAXAHACHIE	Urban	Dallas	68%		782%	850%	367%	406%
316296801	1215296884	TEXAS HEALTH HARRIS METHODIST HOSPITAL ALLIANCE-	Urban	Tarrant	77%	77%	167%	244%	22%	88%
369162801	1538522412	TENET HOSPITALS LIMITED-THE HOSPITALS OF PROVIDENCE TRANSMOUNTAIN CAMPUS	Urban	El Paso	11%		207%	218%	53%	109%
217744601	1902047376	FLOWER MOUND HOSPITAL PARTNERS LLC-TEXAS HEALTH PRESBYTERIAN HOSPITAL FLOWER MOUND	Urban	Tarrant	77%		202%	279%	36%	102%
020977701	1134166192	ORTHOPEDIC HOSPITAL LTD-TEXAS	Urban	Harris	189%		90%	279%	0%	41%
343723801	1427472463	ORTHOPEDIC HOSPITAL	Urban	Bexar	49%		167%	216%	25%	82%
094105602	1518911833	RESOLUTE HOSPITAL COMPANY LLC- COLUMBIA NORTH HILLS HOSPITAL-	Urban	Tarrant	77%		220%	297%	45%	111%
314161601	1124305065	COLUMBIA NORTH HILLS HOSPITAL- BAYLOR MEDICAL CENTERS AT GARLAND AND MCKINNEY-BAYLOR SCOTT AND WHITE MEDICAL CENTER - MCKINNEY	Urban	Dallas	68%		1035%	1103%	883%	922%
412747401	1245878990	WALKER COUNTY HOSPITAL CORPORATION-HUNTSVILLE MEMORIAL HOSPITAL	Urban	Jefferson	84%		0%	84%	0%	113%
110803703	1770579591	FORT DUNCAN REGIONAL MEDICAL CENTER LP-FORT DUNCAN REGIONAL MEDICAL CENTER	Rural	Hidalgo	0%		34%	34%	74%	85%
139172412	1396746129	TEXAS-MEMORIAL MED CTR OF EAST TX	Rural	MRSA Northeast	0%		7%	7%	64%	96%
094164302	1487607792	WOODLAND HEIGHTS MEDICAL CENTER	Rural	MRSA Northeast	0%		51%	51%	45%	77%
193399601	1629138029	ROCKWALL REGIONAL HOSPITAL LLC- TEXAS HEALTH PRESBYTERIAN HOSPITAL ROCKWALL	Urban	Dallas	68%		260%	328%	62%	101%
163111101	1063411767	ESSENT PRMC LP-PARIS REGIONAL MEDICAL CENTER	Rural	MRSA Northeast	0%		18%	18%	69%	101%
121782009	1740288505	UVALDE COUNTY HOSPITAL AUTHORITY-UVALDE MEMORIAL HOSPITAL	Rural	MRSA West	3%		20%	23%	92%	113%
366812101	1033568621	CHRISTUS HOPKINS HEALTH ALLIANCE-CHRISTUS MOTHER FRANCES HOSPITAL - SULPHUR SPRINGS	Rural	MRSA Northeast	0%		31%	31%	0%	32%
131030203	1801831748	NACOGDOCHES COUNTY HOSPITAL DISTRICT-MEMORIAL HOSPITAL	Rural	MRSA Northeast	0%		0%	0%	4%	36%
409332001	1053963009	COLLEGE STATION MEDICAL CENTER	Urban	MRSA Central	50%		0%	50%	549%	658%
094140302	1457382798	TEXAS HEALTH PRESBYTERIAN HOSPITAL KAUFMAN-	Urban	Dallas	68%		277%	345%	65%	104%

130606006	1124076401	DECATUR HOSPITAL AUTHORITY-WISE HEALTH SYSTEM	Rural	Tarrant	0%	33%	33%	71%	106%	177%
349059101	1871917971	SAN ANTONIO BEHAVIORAL HEALTHCARE HOSPITAL, LLC-	Non-State-Owned	Bexar	9%	0%	9%	0%	0%	0%
121829905	1598764359	WEST OAKS HOSPITAL	Non-State-Owned	Harris	22%	0%	22%	0%	0%	0%
130605205	1700885076	NACOGDOCHES MEDICAL CENTER	Rural	MRSA Northeast	0%	42%	42%	32%	43%	75%
191968002	1386779304	UNIVERSITY BEHAVIORAL HEALTH OF EL PASO LLC	Non-State-Owned	El Paso	13%	7%	20%	0%	0%	0%
337433201	1710985098	TIRR MEMORIAL HERMANN	Urban	Harris	189%	394%	583%	41%	0%	41%
138913209	1174526529	TITUS COUNTY MEM HOSP DIST-	Rural	MRSA Northeast	0%	1%	1%	32%	30%	62%
127304703	1508899204	TITUS REGIONAL MEDICAL CENTER TEXAS HEALTH HARRIS METHODIST HOSPITAL AZLE-	Urban	Tarrant	77%	153%	230%	66%	24%	90%
358963201	1255708715	OCH HOLDINGS-OUR CHILDRENS HOUSE	Children's	Dallas	59%	46%	105%	0%	28%	28%
020982701	1548291883	TEXAS HEALTH PRESBYTERIAN HOSPITAL ALLEN-	Urban	Dallas	68%	211%	279%	39%	47%	86%
361635101	1003282039	SUN HOUSTON, LLC-	Non-State-Owned	Harris	22%	68%	90%	0%	0%	0%
112742503	1326015595	Clarity Child Guidance Center 8535 Tom Slick Drive San Antonio, TX 78229	Non-state-owned	Bexar	9%	0%	9%	0%	0%	0%
333289201	1457791105	DALLAS BEHAVIORAL HEALTHCARE HOSPITAL LLC-	Non-State-Owned	Dallas	32%	0%	32%	0%	0%	0%
121816602	1164510673	PALESTINE PRINCIPAL HEALTHCARE LIMITED PARTNERSHIP-PALESTINE REGIONAL MEDICAL	Rural	MRSA Northeast	0%	46%	46%	32%	41%	73%
175965601	1861598633	SHC KPH LP-KINGWOOD PINES HOSPITAL	Non-State-Owned	Harris	22%	6%	28%	0%	0%	0%
021196301	1245344472	TXDSHS dba North Texas State Hospital-Vernon	State-Owned	MRSA West	111%	0%	111%	0%	0%	0%
021240902	1043280951	TEXAS LAUREL RIDGE HOSPITAL LP- LAUREL RIDGE TREATMENT CENTER	Non-State-Owned	Bexar	9%	2%	11%	0%	0%	0%
375837601	1184179194	HOUSTON METHODIST THE METHODIST HEALTH CENTERS- WOODLANDS HOSPITAL	Urban	Harris	189%	162%	351%	41%	34%	75%
119877204	1104830900	VAL VERDE HOSPITAL CORPORATION- VAL VERDE REGIONAL MEDICAL CENTER	Rural	MRSA West	3%	7%	10%	21%	38%	59%
127294003	1790782704	SID PETERSON MEMORIAL HOSPITAL- PETERSON REGIONAL MEDICAL CENTER	Rural	MRSA West	3%	4%	7%	21%	5%	26%
130959304	1679678767	MATAGORDA COUNTY HOSPITAL DISTRICT-MATAGORDA REGIONAL MEDICAL CENTER	Rural	Harris	6%	0%	6%	46%	2%	48%
387381201	1730697350	JACKSONVILLE HOSPITAL LLC-UT HEALTH EAST TEXAS JACKSONVILLE HOSPITAL	Rural	MRSA Northeast	0%	0%	0%	32%	33%	65%
112697102	1689650616	MEMORIAL HOSP OF POLK COUNTY- CHI ST LUKES HEALTH MEMORIAL LIVINGSTON	Rural	Jefferson	0%	0%	0%	25%	64%	89%
112746602	1922078815	GLEN OAKS HOSPITAL INC-GLEN OAKS HOSPITAL	Non-State-Owned	Dallas	32%	0%	32%	0%	0%	0%
112701102	1144274226	NAVARRO REGIONAL HOSPITAL	Rural	Dallas	26%	126%	152%	60%	60%	120%
094178302	1114998911	LAKE GRANBURY MEDICAL CENTER	Rural	Tarrant	0%	163%	163%	71%	156%	227%
094222903	1003885641	CHRISTUS SPOHN HEALTH SYSTEM CORPORATION-	Rural	Nueces	19%	15%	34%	16%	45%	61%
020811801	1447228747	CHRISTUS SPOHN HEALTH SYSTEM CORPORATION-CHRISTUS SPOHN HOSPITAL BEEVILLE	Rural	Nueces	19%	0%	19%	16%	39%	55%
281219001	1407990088	ST LUKES PATIENTS MEDICAL CENTER-	Urban	Harris	189%	0%	189%	41%	149%	190%
387377001	1326546797	HENDERSON HOSPITAL LLC-UT HEALTH EAST TEXAS HENDERSON HOSPITAL	Rural	MRSA Northeast	0%	0%	0%	32%	18%	50%

353712801	1396138970	SCOTT & WHITE HOSPITAL-MARBLE FALLS-BAYLOR SCOTT & WHITE MEDICAL CENTER-MARBLE FALLS	Rural	Travis		18%	17%	35%	18%	13%	31%
021203701	1730187568	CYPRESS CREEK HOSPITAL INC	Non-State-Owned IMD	Harris		22%	0%	22%	0%	0%	0%
136436606	1093783391	CHRISTUS SPOHN HEALTH SYSTEM CORPORATION-CHRISTUS SPOHN HOSPITAL KLEBERG	Rural	Nueces		19%	20%	39%	16%	63%	79%
379200401	1376071530	METHODIST HEALTHCARE SYSTEM OF SAN ANTONIO LTD LLP-METHODIST HOSPITAL SOUTH	Rural	Bexar		63%	40%	103%	18%	39%	57%
388217701	1801826839	BAYLOR SCOTT & WHITE MEDICAL CENTER - CENTENNIAL-	Urban	Dallas		68%	0%	68%	39%	206%	245%
162459501	1942292255	TEXAS SPINE AND JOINT HOSPITAL LTD	Urban	MRSA Northeast		60%	70%	130%	122%	307%	429%
136332705	1760567085	STARR COUNTY MEMORIAL HOSPITAL	Rural	Hidalgo		0%	0%	0%	11%	0%	11%
127263503	1073580726	METHODIST HOSPITAL PLAINVIEW-COVENANT HOSPITAL PLAINVIEW	Rural	Lubbock		67%	12%	79%	50%	309%	359%
094221102	1386652527	CORNERSTONE REGIONAL HOSPITAL	Urban	Hidalgo		74%	26%	100%	58%	15%	73%
094351601	1821061532	HEALTHSOUTH REHABILITATION-ENCOMPASS HEALTH	Urban	MRSA West		40%	0%	40%	93%	0%	93%
162965101	1659352987	REHABILITATION HOSPITAL OF MIDLA USMD HOSPITAL AT ARLINGTON LP	Urban	Tarrant		77%	83%	160%	66%	21%	87%
333086201	1578809505	TEXAS OAKS PSYCHIATRIC HOSPITAL LP-AUSTIN OAKS HOSPITAL	Non-State-Owned IMD	Travis		44%	2%	46%	0%	0%	0%
217547301	1093021719	BEHAVIORAL HEALTH MANAGEMENT, LLC-	Non-State-Owned IMD	Harris		22%	1%	23%	0%	0%	0%
371439601	1154782548	STRATEGIC BH-BROWNSVILLE, LLC-PALMS BEHAVIORAL HEALTH	Non-State-Owned IMD	Hidalgo		14%	1%	15%	0%	0%	0%
121794503	1922031541	TEXAS HEALTH HARRIS METHODIST HOSPITAL STEPHENVILLE-	Rural	MRSA Central		10%	151%	161%	12%	44%	56%
112706003	1598749707	CHRISTUS JASPER MEMORIAL HOSPITAL-	Rural	Jefferson		0%	26%	26%	25%	26%	51%
348990801	1689098790	HOUSTON BEHAVIORAL HEALTHCARE HOSPITAL, LLC-	Non-State-Owned IMD	Harris		22%	0%	22%	0%	0%	0%
308032701	1386902138	PRIME HEALTHCARE SERVICES PAMPA LLC-PAMPA REGIONAL MEDICAL CENTER	Rural	MRSA West		3%	11%	14%	21%	15%	36%
121822403	1700805678	PRHC ENNIS LP-ENNIS REGIONAL MEDICAL CENTER	Urban	Dallas		68%	133%	201%	39%	123%	162%
281514401	1225289499	LUBBOCK HERITAGE HOSPITAL LLC-GRACE MEDICAL CENTER	Urban	Lubbock		0%	175%	175%	79%	21%	100%
021168201	1548233265	HEALTHSOUTH REHAB INSTITUTE OF SAN ANTONIO RIOSA-ENCOMPASS HEALTH REHABILITATION HOSPITAL OF SAN AN	Urban	Bexar		49%	0%	49%	57%	0%	57%
138950412	1972590602	PALO PINTO GENERAL HOSPITAL	Rural	MRSA West		3%	0%	3%	21%	3%	24%
021215104	1689692402	HMH CEDAR CREST LLC-CEDAR CREST HOSPITAL	Non-State-Owned IMD	MRSA Central		59%	0%	59%	0%	0%	0%
313188001	1659539567	HEALTHSOUTH REHABILITATION HOSPITAL OF ABILENE	Urban	MRSA West		40%	0%	40%	93%	0%	93%
217884004	1326134255	DIMMIT REGIONAL HOSPITAL-	Rural	MRSA West		3%	39%	42%	21%	27%	48%
184076101	1205999232	HICKORY TRAIL HOSPITAL LP	Non-State-Owned IMD	Dallas		32%	6%	38%	0%	0%	0%
135226205	1154315307	SCOTT & WHITE HOSPITAL BRENHAM-BAYLOR SCOTT AND WHITE MEDICAL CENTER BRENHAM	Rural	MRSA Central		10%	0%	10%	12%	22%	34%
197063401	1841497153	GPCH LLC-GOLDEN PLAINS COMMUNITY HOSPITAL	Rural	Lubbock		67%	0%	67%	50%	0%	50%
331242301	1851632616	LANCASTER REGIONAL HOSPITAL LP-CRESCENT MEDICAL CENTER	Urban	Dallas		68%	67%	135%	39%	70%	109%

127298107	1174563779	ANDREWS COUNTY HOSPITAL DISTRICT	Rural	MRSA West	3%	0%	3%	21%	0%	21%
133258705	1225146400	METHODIST HOSPITAL LEVELLAND-COVENANT HOSPITAL LEVELLAND	Rural	Lubbock	67%	0%	67%	50%	30%	80%
133244705	1275581852	ROLLING PLAINS MEMORIAL HOSPITAL	Rural	MRSA West	3%	0%	3%	21%	0%	21%
286326801	1154612638	SETON FAMILY OF HOSPITALS-SETON SMITHVILLE REGIONAL HOSPITAL	Urban	Travis	40%	212%	252%	120%	0%	120%
405102101	1285191452	SCENIC MOUNTAIN MEDICAL CENTER	Rural	MRSA West	3%	0%	3%	21%	215%	236%
158977201	1750499273	SETON FAMILY OF HOSPITALS-SETON SOUTHWEST HOSPITAL	Urban	Travis	40%	112%	152%	120%	13%	133%
138911619	1437148020	CUERO COMMUNITY HOSPITAL	Rural	MRSA Central	10%	35%	45%	12%	22%	34%
136430906	1497726343	HILL COUNTRY MEMORIAL HOSPITAL-HILL COUNTRY MEMORIAL HOSP	Rural	MRSA Central	10%	20%	30%	12%	81%	93%
344854001	1215354899	WESTPARK SPRINGS LLC-DEAF SMITH COUNTY HOSPITAL	Non-State-Owned IMD	Harris	22%	0%	22%	0%	0%	0%
133544006	1568454403	DISTRICT-HEREFORD REGIONAL MEDICAL CENTER	Rural	Lubbock	67%	0%	67%	50%	0%	50%
021195501	1477669208	Texas HHSC North Texas State Hospital-Wichita	State-Owned IMD	MRSA West	111%	0%	111%	0%	0%	0%
171848805	1649273434	BAYLOR REGIONAL MEDICAL CENTER AT PLANO-	Urban	Dallas	68%	623%	691%	39%	438%	477%
177658501	1851346407	UHP LP	Non-State-Owned IMD	Tarrant	29%	4%	33%	0%	0%	0%
112745802	1518937218	RIVER CREST HOSPITAL	Non-State-Owned IMD	MRSA West	23%	0%	23%	0%	0%	0%
136330112	1578588463	SCURRY COUNTY HOSPITAL DISTRICT-D.M. COGDELL MEMORIAL HOSPITAL	Rural	MRSA West	3%	4%	7%	21%	0%	21%
212140201	1427048453	MEDINA COUNTY HOSPITAL DISTRICT-MEDINA HEALTHCARE SYSTEM,MEDINA REGIONAL HOSPITAL,	Rural	Bexar	63%	9%	72%	18%	5%	23%
094121303	1821025990	MEMORIAL HOSPITAL	Rural	MRSA West	3%	0%	3%	21%	0%	21%
137909111	1689630865	MEMORIAL MEDICAL CENTER	Rural	Nueces	19%	0%	19%	16%	0%	16%
220238402	1043457583	MEMORIAL HERMANN REHABILITATION HOSPITAL KATY-	Urban	Harris	189%	0%	189%	41%	0%	41%
135151206	1871599829	WILSON COUNTY MEMORIAL HOSPITAL DISTRICT-CONNALLY HOSPITAL MEDICAL CENTER	Rural	Bexar	63%	0%	63%	18%	25%	43%
112751605	1720094550	Texas Department of State Health Services dba El Paso Psychiatric Center	State-Owned IMD	El Paso	77%	4%	81%	0%	0%	0%
133252009	1992285282	NHCL OF HILLSBORO INC-HILL REGIONAL HOSPITAL	Rural	MRSA Central	10%	0%	10%	12%	180%	192%
021194801	1326052226	Texas Department of State Health Services dba Austin State Hospital	State-Owned IMD	Travis	452%	0%	452%	0%	0%	0%
133250406	1326079534	CHILDRESS COUNTY HOSPITAL DISTRICT-CHILDRESS REGIONAL MEDICAL CENTER	Rural	MRSA West	3%	0%	3%	21%	4%	25%
388696201	1184132524	PITTSBURG HOSPITAL LLC-UT HEALTH EAST TEXAS PITTSBURG HOSPITAL	Rural	MRSA Northeast	0%	0%	0%	32%	37%	69%
135033210	1740238641	COLUMBUS COMMUNITY HOSPITAL-MOTHER FRANCES HOSPITAL	Rural	MRSA Central	10%	0%	10%	12%	26%	38%
141858401	1952306672	JACKSONVILLE	Rural	MRSA Northeast	0%	0%	0%	32%	5%	37%
387663301	1538667035	CARTHAGE HOSPITAL LLC-UT HEALTH EAST TEXAS CARTHAGE HOSPITAL	Rural	MRSA Northeast	0%	17%	17%	32%	71%	103%
345305201	1275956807	GEORGETOWN BEHAVIORAL HEALTH INSTITUTE, LLC-GEORGETOWN BEHAVIORAL HEALTH INSTITUTE LLC	Non-State-Owned IMD	Travis	44%	0%	44%	0%	0%	0%
396650901	1972071991	GAINESVILLE COMMUNITY HOSPITAL, INC.-NORTH TEXAS MEDICAL CENTER	Rural	MRSA Northeast	0%	30%	30%	32%	0%	32%
137919003	1992713119	Texas Department of State Health Services dba Terrell State Hospital	State-Owned IMD	Dallas	289%	0%	289%	0%	0%	0%

348183001	1144625153	AUSTIN BEHAVIORAL HOSPITAL LLC-	Non-State-Owned	Travis	44%	0%	44%	0%	0%	0%
140714001	1861487779	CROSS CREEK HOSPITAL	IMD	Travis	10%	0%	10%	12%	0%	0%
311054601	1003192311	LMESTONE MEDICAL CENTER	Rural	MRSA Central	6%	0%	6%	46%	0%	46%
		HEALTHSOUTH PLANO								
094347402	1144294893	REHABILITATION HOSPITAL LLC-	Urban	Dallas	68%	0%	68%	39%	0%	39%
333366801	1750620456	REHABILITATION HOSPITAL	Non-State-Owned	MRSA West	23%	0%	23%	0%	0%	0%
		OCEANS BEHAVIORAL HOSPITAL OF	IMD							
		ABILENE LLC-								
		BEHAVIORAL HEALTH CENTER OF THE								
		PERMIAN BASIN LLC-OCEANS								
335658501	1396184180	BEHAVIORAL HOSPITAL OF PERMIAN	Non-State-Owned	MRSA West	23%	0%	23%	0%	0%	0%
112684904	1831170273	BASIN	IMD	MRSA West	3%	0%	3%	21%	0%	21%
094129604	1700991700	REEVES COUNTY HOSPITAL DISTRICT	Rural	MRSA West	3%	4%	7%	21%	27%	48%
		MOORE COUNTY HOSPITAL-	Rural							
		WOODLAND SPRINGS LLC-WOODLAND	Non-State-Owned							
391264401	1740791748	SPRINGS	IMD	Harris	22%	0%	22%	0%	0%	0%
		FRIO HOSPITAL-FRIO REGIONAL								
112688004	1447574819	SWING BED	Rural	MRSA West	3%	0%	3%	21%	12%	33%
189947801	1134108053	DAWSON COUNTY HOSPITAL	Rural	MRSA West	3%	13%	16%	21%	0%	21%
		DISTRICT-MEDICAL ARTS HOSPITAL								
		HEALTHSOUTH REHABILITATION								
314562501	1982920773	HOSPITAL OF DALLAS LLC-	Urban	Dallas	68%	0%	68%	39%	0%	39%
391576104	1114435260	HOSPITAL OF DALLAS	Rural	MRSA Northeast	0%	0%	0%	32%	0%	32%
		CROCKETT MEDICAL CENTER LLC-								
		CROCKETT MEDICAL CENTER	Rural							
		TEXAS HEART HOSPITAL OF THE								
185556101	1962504340	SOUTHWEST LLP-BAYLOR SCOTT &	Urban	Dallas	68%	986%	1054%	39%	729%	768%
130616909	1760598692	WHITE THE HEART HOSPITAL PLANO	Rural	MRSA West	3%	0%	3%	21%	9%	30%
		PECOS COUNTY MEMORIAL HOSPITAL-								
209190201	1245422567	HEALTHSOUTH REHABILITATION	Urban	Travis	40%	0%	40%	120%	0%	120%
		HOSPITAL OF ROUND ROCK								
		EASTLAND MEMORIAL HOSPITAL								
137074409	1689650921	DISTRICT-EASTLAND MEMORIAL	Rural	MRSA West	3%	3%	6%	21%	0%	21%
		HOSPITAL								
094153604	1356446686	SETON FAMILY OF HOSPITALS-	Rural	Travis	18%	32%	50%	18%	148%	166%
388701003	1477061885	ASCENSION SETON EDGAR B DAVIS	Rural	MRSA Northeast	0%	88%	88%	32%	44%	76%
		QUITMAN HOSPITAL LLC-UT HEALTH								
210433301	1427048743	EAST TEXAS	Rural	MRSA West	23%	0%	23%	0%	0%	0%
151691601	1609855139	RED RIVER HOSPITAL LLC-RED RIVER	Non-State-Owned	Dallas	68%	604%	672%	39%	2270%	2309%
		HOSPITAL	IMD							
		BAYLOR HEART AND VASCULAR	Urban							
134772611	1780823021	CORVELL COUNTY MEMORIAL	Rural	MRSA Central	10%	121%	131%	12%	49%	61%
		HOSPITAL AUTHORITY-								
094151004	1003833013	SETON FAMILY OF HOSPITALS-SETON	Rural	Travis	18%	8%	26%	18%	2138%	2156%
111915801	1497708929	HIGHLAND LAKES	Rural	MRSA Central	10%	346%	356%	12%	162%	174%
		PARKVIEW REGIONAL HOSPITAL								
210274101	1184868879	ST LUKES LAKESIDE HOSPITAL LLC-ST	Urban	Harris	189%	0%	189%	41%	38%	79%
		LUKES LAKESIDE HOSPITAL								
		BAYLOR SCOTT & WHITE MEDICAL								
395486901	1346729159	CENTERS - CAPITOL ARE-BAYLOR	Urban	Travis	40%	2%	42%	120%	0%	120%
020988401	1023011657	SCOTT & WHITE MEDICAL CENTER -	Rural	Harris	6%	0%	6%	46%	0%	46%
		PLUGERVILLE								
094224503	1356312243	SWEENEY COMMUNITY HOSPITAL	Rural	MRSA West	3%	29%	32%	21%	95%	116%
		BIG BEND REGIONAL MEDICAL								
		CENTER								
		KARNES COUNTY HOSPITAL DISTRICT-								
136412710	1699772541	OTTO KAISER MEMORIAL HOSPITAL	Rural	Nueces	19%	196%	215%	16%	6%	22%
		HEALTHSOUTH REHAB HOSPITAL OF								
309446801	1548546088	SOUTH AUSTIN LLC-HEALTHSOUTH	Urban	Travis	40%	13%	53%	120%	0%	120%
		REHABILITATION HOSPITAL OF								
		AUSTIN								

176692501	1659362630	ST MARKS MEDICAL CENTER	Rural	Travis	18%	0%	18%	18%	32%	50%
130618504	1811916901	TERRY MEMORIAL HOSPITAL DISTRICT-BROWNFIELD REGIONAL MEDICAL CENTER	Rural	Lubbock	67%	39%	106%	50%	5%	55%
137227806	1790702371	COUNTY OF YOAKUM-YOAKUM COUNTY HOSPITAL	Rural	MRSA West	3%	10%	13%	21%	2%	23%
282322101	1407169196	AMH CATH LABS, LLC-TEXAS HEALTH HEART & VASCULAR HOSPITAL ARLINGTON	Urban	Tarrant	77%	179%	256%	66%	97%	163%
330811601	1760417646	FANNIN COUNTY HOSPITAL AUTHORITY-TMC BONHAM HOSPITAL	Rural	MRSA Northeast	0%	54%	54%	32%	0%	32%
020990001	1780731737	MADISON ST JOSEPH HEALTH CENTER COUNTY OF WARD-WARD MEMORIAL HOSPITAL	Rural	MRSA Central	10%	0%	10%	12%	40%	52%
136331910	1720096019	ST JOSEPH HEALTHSOUTH REHABILITATION HOSPITAL LLC-CHI ST JOSEPH REHABILITATION HOSPITAL	Rural	MRSA West	3%	0%	3%	21%	0%	21%
368423501	1932573417	PHYSICIANS SURGICAL HOSPITALS LLC-QUAIL CREEK SURGICAL HOSPITAL	Urban	MRSA Central	50%	0%	50%	109%	0%	109%
165305701	1912948845	WILBARGER COUNTY HOSPITAL DISTRICT-WILBARGER GENERAL HOSPITAL	Urban	Lubbock	0%	69%	69%	79%	272%	351%
112707808	1316931835	HAMILTON COUNTY HOSPITAL DISTRICT-HAMILTON GENERAL HOSPITAL	Rural	MRSA West	3%	14%	17%	21%	20%	41%
121792903	1326037607	JACKSON COUNTY HOSPITAL DISTRICT-JACKSON HEALTHCARE CENTER	Rural	MRSA Central	10%	1%	11%	12%	28%	40%
121808305	1124061882	JACK COUNTY HOSPITAL DISTRICT - FAITH COMMUNITY HOSPITAL	Rural	MRSA Central	10%	0%	10%	12%	0%	12%
119874904	1790777696	SCOTT AND WHITE HOSPITAL TAYLOR- BAYLOR SCOTT AND WHITE MEDICAL CENTER TAYLOR	Rural	MRSA West	3%	5%	8%	21%	0%	21%
136327710	1962497800	YOAKUM COMMUNITY HOSPITAL	Rural	Travis	18%	60%	78%	18%	11%	29%
112673204	1881697878	BOSQUE COUNTY HOSPITAL DISTRICT- GOODALL-WITCHER HOSPITAL	Rural	MRSA Central	10%	16%	26%	12%	34%	46%
401736001	1104383371	REHABILITATION HOSPITAL LLC-UT HOSPITAL	Rural	MRSA Central	10%	98%	108%	12%	408%	420%
389645801	1174021695	GRAHAM HOSPITAL DISTRICT- GRIMES ST JOSEPH HEALTH CENTER	Urban	MRSA Northeast	60%	0%	60%	122%	0%	122%
346945401	1881691061	COON MEMORIAL HOSPITAL AND CLINIC	Rural	MRSA West	3%	0%	3%	21%	0%	21%
147918003	1154317774	REFUGIO COUNTY MEMORIAL HOSPITAL DISTRICT	Rural	MRSA Central	10%	0%	10%	12%	10%	22%
130826407	1639176456	MOTHER FRANCES HOSPITAL WINNSBORO	Rural	MRSA West	3%	0%	3%	21%	0%	21%
133367602	1841294246	WINNSBORO	Rural	MRSA Central	10%	14%	24%	12%	25%	37%
020991801	1942240189	COMPANY-COMANCHE COUNTY MEDICAL CENTER	Rural	Nueces	19%	0%	19%	16%	23%	39%
127301306	1659308948	LUBBOCK REGIONAL MHMR CENTER COMANCHE COUNTY MEDICAL CENTER	Rural	MRSA Northeast	0%	0%	0%	32%	4%	36%
136492909	1265648513	BURLESON ST JOSEPH HEALTH CENTER-BURLESON ST. JOSEPH HEALTH CENTER	Non-State-Owned IMD	Lubbock	0%	0%	0%	0%	0%	0%
281406304	1346544616	CHRISTUS HEALTH ARK LA TEX- CHRISTUS ST MICHAEL REHABILITATION HOSPITAL	Rural	MRSA Central	10%	0%	10%	12%	3%	15%
112725003	1750377289	METROPLEX ADVENTIST HOSPITAL INC-ROLLINS BROOK COMMUNITY HOSPITAL	Rural	MRSA Central	10%	0%	10%	12%	34%	46%
094353202	1467453902		Urban	MRSA Northeast	60%	376%	436%	122%	0%	122%
149073203	1750392916		Rural	MRSA Central	10%	170%	180%	12%	29%	41%



112704504	1245237593	OCHILTREE GENERAL HOSPITAL	Rural	MRSA West	3%	0%	3%	21%	2%	23%
171461001	1629064928	SOUTHLAKE SPECIALTY HOSPITAL LLC TEXAS HEALTH HARRIS METHODIST HOSPITAL SOUTHLAKE	Urban	Tarrant	77%	0%	77%	66%	211%	277%
135034009	1871583153	ELECTRA HOSPITAL DISTRICT-	Rural	MRSA West	3%	110%	113%	21%	0%	21%
316360201	1407121189	PREFERRED HOSPITAL LEASING COLEMAN INC-COLEMAN COUNTY MEDICAL CENTER COMPANY	Rural	MRSA West	3%	0%	3%	21%	0%	21%
138353107	1194893263	BAYLOR COUNTY HOSPITAL DISTRICT-	Rural	MRSA West	3%	16%	19%	21%	27%	48%
322916301	1558349399	SEYMOUR HOSPITAL HEART OF TEXAS HEALTHCARE SYSTEM-	Rural	MRSA West	3%	37%	40%	21%	14%	35%
138706004	1972511921	Texas Department of State Health Services dba San Antonio State Hospital	State-Owned IMD	Bexar	38%	0%	38%	0%	0%	0%
284333604	1154324952	LIBERTY COUNTY HOSPITAL DISTRICT	Rural	Jefferson	0%	0%	0%	25%	0%	25%
127313803	1700854288	NO 1-LIBERTY DAYTON REGIONAL MEDICAL CENTER	Rural	Lubbock	67%	0%	67%	50%	9%	59%
220798701	1326349986	LAMB HEALTHCARE CENTER SCOTT AND WHITE HOSPITAL - LLANO BAYLOR SCOTT AND WHITE MEDICAL CENTER - LLANO	Rural	MRSA Central	10%	0%	10%	12%	0%	12%
021224301	1831140698	GREEN OAKS HOSPITAL SUBSIDIA	Non-State-Owned	Dallas	32%	67%	99%	0%	0%	0%
020993401	1174522494	BAYSIDE COMMUNITY HOSPITAL -	Rural	Jefferson	0%	0%	0%	25%	0%	25%
136325111	1184631673	MITCHELL COUNTY HOSPITAL	Rural	MRSA West	3%	6%	9%	21%	0%	21%
337991901	1285065623	HOSPITAL	Rural	MRSA West	3%	0%	3%	21%	3%	24%
136145310	1679560866	STEPHENS MEMORIAL HOSPITAL	Rural	MRSA West	3%	0%	3%	21%	3%	36%
110856504	1134137466	MARTIN COUNTY HOSPITAL DISTRICT	Rural	MRSA West	3%	9%	12%	21%	4%	25%
126667806	1104842475	HAMILTON HOSPITAL	Rural	MRSA West	67%	99%	166%	50%	0%	50%
083290905	1477857332	WJ MANGOLD MEMORIAL HOSPITAL BELLVILLE ST JOSEPH HEALTH CENTER-	Rural	Lubbock	6%	95%	101%	46%	0%	46%
121692107	1861510521	HARDEMAN COUNTY MEMORIAL HOSPITAL	Rural	MRSA West	3%	0%	3%	21%	0%	21%
200683501	1932379856	PREFERRED HOSPITAL LEASING HEMPHILL INC-SABINE COUNTY HOSPITAL	Rural	MRSA Northeast	0%	0%	0%	32%	0%	32%
130734007	1578547345	MEMORIAL MEDICAL CENTER SAN AUGUSTINE	Rural	MRSA Northeast	0%	0%	0%	32%	0%	32%
316076401	15182553194	SWISHER MEMORIAL HEALTHCARE SYSTEM-SWISHER MEMORIAL HOSPITAL	Rural	Lubbock	67%	140%	207%	50%	0%	50%
174662001	1316933609	PHYSICIANS MEDICAL CENTER LLC- TEXAS HEALTH CENTER FOR DIAGNOSTICS AND SURGERY PL	Urban	Dallas	68%	0%	68%	39%	129%	168%
350190001	1619368339	PREFERRED HOSPITAL LEASING MULESHOE INC-MULESHOE AREA MEDICAL CENTER	Rural	MRSA West	3%	8%	11%	21%	11%	32%
212060201	1205164928	CAHRMC LLC-RICE MEDICAL CENTER	Rural	MRSA Central	10%	0%	10%	12%	0%	12%
136381405	1447259627	TYLER COUNTY HOSPITAL	Rural	Jefferson	0%	4%	4%	25%	29%	54%
216719901	1700826575	SOMERVELL COUNTY HOSPITAL DISTRICT-GLEN ROSE MEDICAL CENTER	Rural	MRSA Central	10%	16%	26%	12%	27%	39%
148698701	1295781227	WINNIE COMMUNITY HOSPITAL LLC	Rural	Jefferson	0%	0%	0%	25%	0%	25%
199602701	1316197767	CRANE COUNTY HOSPITAL DISTRICT- CRANE MEMORIAL HOSPITAL	Rural	MRSA West	3%	53%	56%	21%	0%	21%
094117105	1992707780	HANSFORD COUNTY HOSPITAL DISTRICT-HANSFORD COUNTY HOSPITAL	Rural	MRSA West	3%	0%	3%	21%	19%	40%
136142011	1033118716	CASTRO COUNTY HOSPITAL DISTRICT-	Rural	MRSA West	3%	0%	3%	21%	0%	21%
135233809	1992767511	PLAINS MEMORIAL HOSPITAL LAVACA MEDICAL CENTER	Rural	MRSA Central	10%	0%	10%	12%	0%	12%

121781205	1831140979	LILLIAN M HUDSPETH MEMORIAL ER PHYS-LILLIAN M HUDSPETH MEMORIAL HOSPITAL	Rural	MRSA West	3%	13%	16%	21%	15%	36%
094180903	1821066820	LYNN COUNTY HOSPITAL-LYNN COUNTY HOSPITAL DISTRICT	Rural	Lubbock	67%	0%	67%	50%	0%	50%
152686501	1780786699	PALACIOS COMMUNITY MEDICAL CENTER	Rural	Harris	6%	0%	6%	46%	0%	46%
130089906	1225038938	BALLINGER MEMORIAL HOSPITAL	Rural	MRSA West	3%	47%	50%	21%	0%	21%
127310404	1689655912	NOCONA HOSPITAL DISTRICT - NOCONA GENERAL HOSPITAL	Rural	MRSA Northeast	0%	37%	37%	32%	8%	40%
112702904	1184607897	HASKELL MEMORIAL HOSPITAL	Rural	MRSA West	3%	0%	3%	21%	21%	42%
021189801	1023015120	MILLWOOD HOSPITAL	Non-State-Owned IMD	Tarrant	29%	0%	29%	0%	0%	0%
319209801	1013941780	COVENANT LONG TERM CARE LP- COVENANT SPECIALTY HOSPITAL	Urban	Lubbock	0%	0%	0%	79%	0%	79%
364187001	1457393571	ANSON HOSPITAL DISTRICT - HEALTHSOUTH REHABILITATION	Rural	MRSA West	3%	34%	37%	21%	33%	54%
199238002	1720279342	HOSPITAL OF RICHARDSON	Urban	Dallas	68%	0%	68%	39%	0%	39%
121053605	1487639175	KNOX COUNTY HOSPITAL DISTRICT- KNOX COUNTY HOSPITAL	Rural	MRSA West	3%	0%	3%	21%	0%	21%
137343308	1861475626	PARMER COUNTY COMMUNITY HOSPITAL	Rural	MRSA West	3%	0%	3%	21%	0%	21%
020992601	1083612121	STONEWALL MEMORIAL HOSPITAL DISTRICT-STONEWALL MEMORIAL HOSPITAL	Rural	MRSA West	3%	2%	5%	21%	0%	21%
339869503	1184056954	ROCK SPRINGS, LLC- PREFERRED HOSPITAL LEASING	Non-State-Owned IMD	Travis	44%	0%	44%	0%	0%	0%
206083201	1164688495	JUNCTION INC-KIMBLE HOSPITAL	Rural	MRSA West	3%	6%	9%	21%	13%	34%
163219201	1922001775	LUBBOCK HEART HOSPITAL LLC-	Urban	Lubbock	0%	224%	224%	79%	105%	184%
121193005	1538150370	LUBBOCK HEART HOSPITAL	Rural	MRSA West	3%	0%	3%	21%	0%	21%
109588703	1558354241	SHAMROCK GENERAL HOSPITAL	Rural	MRSA West	3%	29%	32%	21%	0%	21%
		HEMPHILL COUNTY HOSPITAL								
126840107	1477594299	PREFERRED HOSPITAL LEASING INC- COLLINGSWORTH GENERAL HOSPITAL	Rural	MRSA West	3%	1%	4%	21%	0%	21%
112692202	1598746703	FISHER COUNTY HOSPITAL-FISHER COUNTY HOSPITAL DISTRICT	Rural	MRSA West	3%	0%	3%	21%	0%	21%
112728403	1083619712	GENERAL HOSPITAL-TRAAN GENERAL HOSPITAL	Rural	MRSA West	3%	0%	3%	21%	0%	21%
094172602	1023013935	MCCAMEY HOSPITAL	Rural	MRSA West	3%	92%	95%	21%	0%	21%
091770005	1326025701	CONCHO COUNTY HOSPITAL	Rural	MRSA West	3%	0%	3%	21%	6%	27%
176354201	1013970862	PREFERRED HOSPITAL LEASING VAN HORN INC-CULBERSON HOSPITAL	Rural	MRSA West	3%	6%	9%	21%	0%	21%
		PREFERRED HOSPITAL LEASING ELDORADO INC-SCHLEICHER COUNTY MEDICAL CENTER								
179272301	1295764553	NORTH WHEELER COUNTY HOSPITAL	Rural	MRSA West	3%	0%	3%	21%	0%	21%
121787905	1396748471	DISTRICT-PARKVIEW HOSPITAL	Rural	MRSA West	3%	16%	19%	21%	0%	21%
		WINKLER COUNTY HOSPITAL								
402628801	1730183658	DISTRICT-WINKLER COUNTY MEMORIAL HOSPITAL	Rural	MRSA West	3%	0%	3%	21%	0%	21%
121806703	1881697316	REAGAN HOSPITAL DISTRICT-REAGAN MEMORIAL HOSPITAL	Rural	MRSA West	3%	0%	3%	21%	168%	189%
359590201	1649646415	GARLAND BEHAVIORAL HOSPITAL	Non-State-Owned IMD	Dallas	32%	72%	104%	0%	0%	0%
120745806	1699770149	MUENSTER HOSPITAL DISTRICT- MUENSTER MEMORIAL HOSPITAL	Rural	MRSA Northeast	0%	0%	0%	32%	0%	32%
		TEXAS INSTITUTE FOR SURGERY AT TEXAS HEALTH PRESBY								
173574801	1245201656	SETON SHOAL CREEK HOSPITAL	Urban	Dallas	68%	0%	68%	39%	144%	183%
094382101	1538264866	RANKIN COUNTY HOSPITAL DISTRICT	Non-State-Owned IMD	Travis	44%	0%	44%	0%	0%	0%
121799406	1295739258	RANKIN COUNTY HOSPITAL DISTRICT	Rural	MRSA West	3%	0%	3%	21%	0%	21%
283280001	1871898478	MAYHILL BEHAVIORAL HEALTH LLC-	Urban	Tarrant	77%	0%	77%	66%	25%	91%

192996002	1962614834	HORIZON HEALTH AUSTIN INC- AUSTIN LAKES HOSPITAL	Non-State-Owned IMD	Travis	44%	78%	122%	0%	0%	0%
021175701	1649243353	HEALTHSOUTH REHABILITATION OF TEXARKANA INC-ENCOMPASS HEALTH REHABILITATION HOSPITAL OF TEXARK	Urban	MRSA Northeast	60%	492%	552%	122%	0%	122%
088189803	1356418974	THROCKMORTON COUNTY MEMORIAL HOSPITAL-	Rural	MRSA West	3%	0%	3%	21%	0%	21%
133257904	1841354677	Texas DSHS TCID	State-Owned Non- IMD	Bexar	0%	0%	0%	0%	0%	0%
388635001	1013085083	SCOTT & WHITE CONTINUING CARE HOSPITAL-BAYLOR SCOTT & WHITE CONTINUING CARE HOSPITAL	Urban	MRSA Central	50%	0%	50%	109%	0%	109%
021219301	1821161167	Texas HHSC Rio Grande State Center	State-Owned IMD	Hidalgo	7%	5%	12%	0%	0%	0%
314300001	1134401466	CARROLLTON SPRINGS LLC	Non-State-Owned IMD	Tarrant	29%	0%	29%	0%	0%	0%
342897103	1306268321	HOUSTON METHODIST ST CATHERINE HOSPITAL-HOUSTON METHODIST CONTINUING CARE HOSPITAL	Urban	Harris	189%	0%	189%	41%	0%	41%
094205403	1730278417	TEXAS HEALTH SPECIALTY HOSPITAL FORT WORTH-	Urban	Tarrant	77%	0%	77%	66%	0%	66%
330388501	1194753590	THIBP MANAGEMENT COMPANY LLC- BAYLOR SCOTT AND WHITE THE HEART HOSPITAL DENTON	Urban	Tarrant	77%	0%	77%	66%	0%	66%
184505902	1316911068	TRINITY MOTHER FRANCES REHABILITATION HOSPITAL- CHRISTUS TRINITY MOTHER FRANCES REHABILITATION HOS	Urban	MRSA Northeast	60%	0%	60%	122%	0%	122%
094352403	1194798801	HEALTHSOUTH REHABILITATION HOSPITAL THE WOODLANDS- ENCOMPASS HEALTH	Urban	Harris	189%	0%	189%	41%	0%	41%
315341301	1376829812	HEALTHSOUTH REHABILITATION HOSPITAL OF VINTAGE PAR- HEALTHSOUTH REHABILITATION HOSPITAL THE VINTAGE	Urban	Harris	189%	0%	189%	41%	0%	41%
094349003	1689648339	CMS REHAB OF WF LP-ENCOMPASS HEALTH REHABILITATION HOSPITAL OF WICHT	Urban	MRSA West	40%	0%	40%	93%	0%	93%
219907701	1518287721	HEALTHSOUTH REHABILITATION HOSPITAL OF SUGAR LAND- HEALTHSOUTH SUGAR LAND REHABILITATION HOSPITAL	Urban	Harris	189%	0%	189%	41%	0%	41%
209804801	1477731156	HEALTHSOUTH REHABILITATION HOSPITAL NORTH HOUSTON- ENCOMPASS HEALTH	Urban	Harris	189%	0%	189%	41%	0%	41%
337018101	1366871600	HEALTH SOUTH REHABILITATION HOSPITAL OF HUMBLE-	Urban	Harris	189%	0%	189%	41%	0%	41%
301006801	1275813610	HEALTHSOUTH REHABILITATION HOSPITAL OF CYPRESS LLC- THE MID-CITIES LLC-RELIANT REHABILITATION HOSPITAL MID CITIES	Urban	Harris	189%	0%	189%	41%	0%	41%
288662403	1427374222	HEALTH SOUTH CITY VIEW REHABILITATION HOSPITAL- ENCOMPASS HEALTH	Urban	Tarrant	77%	0%	77%	66%	0%	66%
199329702	1699749341	REHABILITATION HOSPITAL OF CITY V	Urban	Tarrant	77%	0%	77%	66%	0%	66%
021173202	1821062050	HEALTHSOUTH REHABILITATION HOSPITAL OF ARLINGTON	Urban	Tarrant	77%	0%	77%	66%	0%	66%

127262703	1073511762	BAYLOR MED CTR AT GRAPEVINE-	Urban	Tarrant	77%	0%	77%	66%	0%	66%
133331202	1942218581	BAYLOR SCOTT AND WHITE MEDICAL	State-Owned IMD	MRSA Northeast	0%	0%	0%	0%	0%	0%
137918204	1881600682	Texas HHSC Rusk State Hospital	State-Owned IMD	MRSA West	111%	0%	111%	0%	0%	0%
127320302	1407862170	Texas HHSC Big Spring State Hospital	State-Owned IMD	MRSA West	111%	0%	111%	0%	0%	0%
339487601	1366880627	Texas HHSC Kerrville State Hospital	Non-State-Owned IMD	Tarrant	29%	0%	29%	0%	0%	0%
418113301	1821612284	MESA SPRINGS, LLC-	Non-State-Owned IMD	Dallas	32%	0%	32%	0%	0%	0%
415930301	128528640	Kindred BH Acquisition 1, LLC d/b/a	Non-State-Owned IMD	Tarrant	29%	0%	29%	0%	0%	0%
414962701	1942795133	WellBridge Hospital Greater Dallas	Non-State-owned	Travis	40%	0%	40%	120%	0%	120%
400811201	1346724879	Kindred BH Acquisition 2, LLC d/b/a	IMD	El Paso	13%	0%	13%	0%	0%	0%
376537203	1235685892	Ascension Seton Bastrop	Rural	MRSA Central	10%	126%	136%	12%	12%	24%
414763901	1104381292	El Paso Behavioral Health, LLC DBA Rio	Urban	Dallas	68%	0%	68%	39%	0%	39%
382091201	1144756578	Vista Behavioral Health	Urban	Harris	189%	0%	189%	41%	0%	41%
413256501	1154893675	Fairfield Hospital District	Urban	Lubbock	0%	0%	0%	79%	0%	79%
Pending 1	1356960132	DBA Freestone Medical Center	Urban	Tarrant	77%	0%	77%	66%	0%	66%
Pending 2	1487271375	Texas Health Frisco	Urban	Dallas	68%	0%	68%	39%	0%	39%
420957901	1184233785	Encompass Health Rehabilitation	Rural	MRSA West	3%	0%	3%	21%	134%	155%
407926101	1144781501	Hospital of Pearland	Urban	Travis	40%	0%	40%	120%	0%	120%
138644310	1528064649	South Plains Rehabilitation Hospital, an	Urban	MRSA West	40%	115%	155%	93%	0%	93%
380473401	1003344334	affiliates of UMC and Encompass Health	Urban	El Paso	11%	73%	84%	56%	0%	56%
309798201	1669752234	Hendrick Medical Center Abilene	Urban	Bexar	49%	116%	165%	57%	44%	101%
220351501	1013957836	HENRICK MEDICAL CENTER	Urban	MRSA Northeast	60%	100%	160%	122%	41%	163%
219336901	1861690364	BAYLOR SCOTT & WHITE MEDICAL	Urban	Dallas	68%	0%	68%	39%	69%	108%
315440301	1760628184	CENTERS - CAPITOL AREA	Children's	Dallas	59%	0%	59%	0%	49%	49%
413256501	1154893675	HONORIS OF PROVIDENCE	Urban	Lubbock	0%	0%	0%	79%	0%	79%
348928801	1679903967	EMERUS BHS SA THOUSAND OAKS	Urban	Tarrant	77%	0%	77%	66%	97%	163%
		LLC-BAPTIST EMERGENCY HOSPITAL	Urban							
		SHAVANO PARK	Urban							
		SHERMAN GRAYSON HOSPITAL LLC-	Urban							
		SHERMAN GRAYSON HEALTH SYSTEM	Urban							
		DALLAS MEDICAL CENTER LLC-	Urban							
		TEXAS SCOTTISH RITE HOSPITAL FOR	Urban							
		CRIPPLED CHILDREN-	Urban							
		South Plains Rehabilitation Hospital, an	Urban							
		affiliates of UMC and Encompass Health	Urban							
		Baylor Scott & White Emergency	Urban							
		Hospital Burleson	Urban							

## IGT Recommendations by SDA

	4,728,305,922	291,892,432	5,020,198,353	2,008,782,169	1,004,391,085	1,004,391,085	1,004,391,085	
SDA	Hospitals Receive	MCO Retains	Total	Suggested Total IGT for Declaration of Intent after 8% (12 months)	Suggested IGT for 1st 6 months	Suggested IGT for 2nd 6 months	Placeholder for IGT Received in June	Cutback
Bexar	412,919,213	25,474,160	438,393,373	175,418,724	87,709,362	87,709,362	87,709,362	100%
Dallas	740,459,139	45,834,379	786,293,519	314,627,489	157,313,744	157,313,744	157,313,744	100%
El Paso	161,424,356	9,938,754	171,363,110	68,569,235	34,284,617	34,284,617	34,284,617	100%
Harris	1,399,506,550	86,364,513	1,485,871,063	594,556,447	297,278,224	297,278,224	297,278,224	100%
Hidalgo	315,287,048	19,425,074	334,712,121	133,931,708	66,965,854	66,965,854	66,965,854	100%
Jefferson	56,528,484	3,505,810	60,034,294	24,022,122	12,011,061	12,011,061	12,011,061	100%
Lubbock	116,572,722	7,187,131	123,759,854	49,521,268	24,760,634	24,760,634	24,760,634	100%
MRSA Central	163,506,827	10,123,792	173,630,619	69,476,556	34,738,278	34,738,278	34,738,278	100%
MRSA Northeast	180,469,927	11,222,696	191,692,623	76,703,886	38,351,943	38,351,943	38,351,943	100%
MRSA West	146,183,025	9,048,019	155,231,044	62,114,150	31,057,075	31,057,075	31,057,075	100%
Nueces	182,379,409	11,204,999	193,584,408	77,460,865	38,730,432	38,730,432	38,730,432	100%
Tarrant	559,394,133	34,474,664	593,868,797	237,630,660	118,815,330	118,815,330	118,815,330	100%
Travis	293,675,089	18,088,440	311,763,529	124,749,058	62,374,529	62,374,529	62,374,529	100%





















STAR	42%
	72%
	0%

## Comprehensive Hospital Increase Reimbursement Program for FY 2022 Preliminary Modeling

Totals:	1,750,478,086	645,211,703	2,395,689,789	2,809,044,069	1,778,139,142	4,587,183,211	UHRIP Rate Increase based on IP Medicare Gap	UHRIP Rate Increase based on OP Medicare Gap	IP UHRIP Payment	OP UHRIP Payment	Total UHRIP Payment	1,719,757,432	2,453,658,305	658,590,064	1,795,068,241	UHRIP Rate Increase based on IP Medicare Gap	UHRIP Rate Increase based on OP Medicare Gap	IP UHRIP Payment	OP UHRIP Payment	Total UHRIP Payment	1,719,757,432	2,453,658,305	554,890,184	2,274,647,616	4,728,305,922	419
Inpatient Rate Class	IP Medicare UPL Gap	OP Medicare UPL Gap	Total Medicare UPL Gap	PGY 5 IP Encounters	PGY 5 OP Encounters	PGY5 Encounters						IP ACIA Payment	OP ACIA Payment	Total ACIA Payment	Total CHRP Payment	Number of Hospitals										
Urban Harris	831,480,782	101,121,991	932,602,774	439,325,918	249,117,877	688,443,794	189%	41%	830,325,985	102,138,329	932,464,314	98,799,149	42,133,876	140,932,025	1,073,396,339	44										
Urban Dallas	130,873,783	43,336,939	174,210,722	439,325,918	249,117,877	688,443,794	68%	41%	830,325,985	102,138,329	932,464,314	98,799,149	42,133,876	140,932,025	1,073,396,339	44										
Urban Bexar	105,051,140	55,287,611	160,338,751	216,135,122	96,355,013	312,490,135	49%	33%	130,091,165	43,403,421	173,494,586	240,697,951	59,105,348	299,802,743	473,500,329	10										
Children's Harris	88,104,938	2,410,512	90,515,450	286,786,954	259,985,377	546,766,330	31%	1%	88,902,096	54,922,357	143,825,567	156,895,184	72,795,905	226,691,089	326,616,472	10										
State-Owned Non-IMD Harris	43,855,765	54,351,440	98,207,205	40,913,350	40,913,350	81,826,700	50%	100%	43,994,119	54,469,762	98,463,881	44,806,754	54,469,762	99,275,904	153,745,666	1										
Urban Lubbock	125,361,277	59,744,207	185,105,484	169,886,755	102,901,722	272,788,483	74%	50%	125,716,199	59,683,002	185,399,201	93,671,036	29,947,495	123,618,531	209,047,732	12										
Urban Dallas	96,344,049	(11,735,499)	84,608,548	163,249,507	236,110,435	399,359,942	59%	0%	96,317,209	-	96,317,209	156,064,576	65,407,969	161,472,175	221,476,149	4										
Urban Tarrant	109,549,530	46,522,666	156,072,196	142,621,647	70,769,557	213,391,205	77%	66%	121,101,379	46,707,908	167,809,287	156,955,446	20,863,987	177,819,433	227,683,424	32										
Children's Tarrant	12,239,351	12,002,801	24,242,152	121,101,379	87,110,809	208,212,187	10%	14%	12,110,138	12,110,138	24,220,276	146,532,668	38,228,756	184,861,424	209,167,075	1										
State-Owned Non-IMD Dallas	16,733,392	15,964,008	32,697,400	13,718,490	13,718,490	27,436,980	30%	81%	16,577,722	15,971,772	32,549,494	34,441,897	6,025,800	40,467,697	73,017,386	4										
Urban El Paso	6,565,164	19,251,828	25,816,992	62,485,692	34,378,711	96,864,404	11%	56%	6,873,266	19,252,078	26,125,344	94,030,788	14,309,200	108,339,578	134,465,082	7										
Children's Nuces	40,721,975	34,876,709	75,598,684	102,312,708	29,072,067	131,384,775	40%	120%	40,925,083	34,886,480	75,811,563	95,475,690	16,404,075	92,275,765	107,680,832	19										
Urban Tarrant	17,068,001	7,832,477	24,900,477	56,591,987	73,810,919	130,402,907	30%	11%	16,977,996	8,119,201	25,097,197	63,383,026	14,024,075	77,407,100	102,503,998	1										
State-Owned Non-IMD Dallas	22,695,731	24,242,152	46,937,883	10,206,528	10,206,528	20,413,056	40%	16%	22,695,731	24,242,152	46,937,883	46,937,883	14,309,200	61,247,083	75,556,283	9										
Urban Dallas	30,722,319	12,955,888	43,678,207	63,649,723	24,895,121	88,544,844	48%	52%	30,551,867	12,945,463	43,497,330	10,183,556	18,422,390	28,605,345	71,033,425	1										
Children's Travis	(7,120,589)	7,001,127	(119,462)	55,739,533	17,258,987	72,998,520	0%	41%	-	7,076,021	7,076,021	82,494,509	20,882,891	103,377,400	110,453,420	1										
Urban Jefferson	19,806,806	16,162,641	35,969,447	23,508,514	14,331,764	37,840,278	84%	11%	19,747,152	16,194,893	35,942,045	13,475,556	3,154,158	16,630,014	52,572,059	4										
Children's Lubbock	(8,313,527)	5,015,133	(3,298,394)	29,796,203	9,192,542	38,988,746	0%	55%	5,055,898	5,055,898	10,111,796	15,791,988	11,490,678	27,282,666	32,338,544	1										
State-Owned Non-IMD Dallas	9,868,759	5,125,844	15,064,603	10,206,528	10,206,528	20,413,056	97%	134%	9,900,132	5,148,476	15,048,608	12,145,168	2,337,101	14,385,869	29,541,577	1										
State-Owned Non-IMD Dallas	(1,480)	2,425,905	2,424,425	464,849	464,849	929,698	0%	54%	2,447,019	2,447,019	4,894,038	-	-	-	2,447,019	1										
Rural Hidalgo	(1,466,714)	662,671	(804,043)	6,270,845	6,270,845	12,541,690	0%	11%	689,793	689,793	1,379,586	2,557,939	2,680,033	5,237,972	5,927,765	2										
Rural MSRA Northeast	(727,725)	10,556,637	9,828,912	33,217,552	33,217,552	66,435,104	0%	37%	10,629,617	10,629,617	21,259,234	11,044,449	10,775,429	21,824,663	31,919,944	22										
Rural MSRA West	1,065,584	6,815,152	7,880,736	32,084,518	32,084,518	64,169,036	21%	21%	6,737,749	6,737,749	13,475,498	3,083,693	9,085,263	12,168,756	20,000,432	62										
Non-State-Owned Non-IMD Dallas	1,863,985	3,093,043	4,956,028	4,247,613	4,247,613	8,495,226	0%	0%	3,013,244	3,013,244	6,026,488	6,026,488	5,387,142	11,413,630	16,790,818	5										
Non-State-Owned Non-IMD Harris	5,852,008	26,064,106	31,916,114	26,064,106	26,064,106	52,128,212	22%	0%	5,734,103	3,506,627	9,240,730	3,506,627	-	3,506,627	9,240,730	8										
Non-State-Owned Non-IMD El Paso	568,351	-	568,351	4,328,033	4,328,033	8,656,066	13%	0%	562,644	-	562,644	271,066	-	271,066	833,710	2										
Non-State-Owned Non-IMD Dallas	2,042,668	6,313,231	8,355,899	6,313,231	6,313,231	12,626,462	32%	0%	2,020,234	445,035	2,465,269	-	-	2,465,269	2,465,269	6										
State-Owned Non-IMD Dallas	1,018,780	1,018,780	2,037,560	12,626,462	12,626,462	25,252,924	111%	0%	1,017,140	-	1,017,140	-	-	-	1,017,140	4										
Rural Harris	266,007	1,965,965	2,231,972	4,128,116	4,128,116	8,256,232	6%	46%	247,687	1,966,215	2,213,902	6,644	48,720	55,484	2,269,386	5										
Rural Jefferson	(671,035)	1,503,717	832,682	6,092,108	6,092,108	12,182,216	0%	23%	1,510,367	1,510,367	3,020,734	1,644,916	2,381,652	2,440,058	3,956,425	6										
Rural Dallas	736,648	1,330,619	2,067,267	2,855,451	2,855,451	5,710,902	26%	60%	742,417	1,330,317	2,072,734	3,597,668	1,339,317	4,937,185	7,018,419	1										
Rural Nuces	1,486,755	1,384,321	2,871,076	7,728,555	7,728,555	15,457,110	19%	16%	1,467,665	1,347,114	2,814,779	861,619	3,181,317	4,043,336	6,838,135	6										
Rural Bexar	1,280,886	956,973	2,237,859	2,217,469	2,217,469	4,434,938	63%	18%	1,284,102	926,444	2,210,546	6,264,915	1,662,185	1,882,680	4,099,227	3										
Rural Lubbock	4,747,889	3,854,451	8,602,340	7,050,025	7,050,025	14,100,050	67%	50%	4,723,516	3,858,762	8,582,278	6,731,001	6,321,644	6,794,945	15,377,223	9										
Non-State-Owned Non-IMD Travis	1,893,759	1,893,759	3,787,518	4,344,052	4,344,052	8,688,104	44%	0%	1,911,383	-	1,911,383	68,037	-	68,037	1,979,420	6										
Non-State-Owned Non-IMD Hidalgo	310,720	2,774,052	3,084,772	2,774,052	2,774,052	5,548,104	14%	0%	318,867	2,774,052	3,092,919	22,741	-	22,741	34,108	1										
State-Owned Non-IMD Harris	1,656,117	2,643,916	4,299,033	2,643,916	2,643,916	5,287,832	59%	0%	1,701,067	1,701,067	3,402,134	3,084,461	4,918,910	8,003,271	10,505,133	14										
Non-State-Owned Non-IMD Harris	1,201,876	-	1,201,876	2,643,916	2,643,916	5,287,832	0%	0%	1,208,851	-	1,208,851	-	-	-	1,208,851	1										
Non-State-Owned Non-IMD El Paso	1,041,672	4,533,426	5,575,098	4,533,426	4,533,426	9,070,192	23%	0%	1,042,688	-	1,042,688	-	-	-	1,042,688	4										
State-Owned Non-IMD El Paso	187,694	187,694	375,388	244,428	244,428	488,856	77%	0%	188,209	9,777	198,006	-	-	9,777	197,866	1										
State-Owned Non-IMD Travis	530,512	530,512	1,061,024	117,255	117,255	234,510	42%	0%	529,995	-	529,995	-	-	-	529,995	1										
Non-State-Owned Non-IMD Lubbock	749,221	749,221	1,498,442	1,498,442	1,498,442	2,996,884	2%	0%	749,221	-	749,221	-	-	-	749,221	1										
Non-State-Owned Non-IMD Bexar	40,526	40,526	81,052	107,546	107,546	215,092	38%	0%	40,867	-	40,867	-	-	-	40,867	1										
State-Owned Non-IMD Bexar	192,451	192,451	384,902	192,451	192,451	384,902	0%	0%	-	-	-	-	-	-	-	1										
State-Owned Non-IMD Hidalgo	255	255	510	3,697	3,697	7,394	7%	0%	259	-	259	185	-	185	444	1										
State-Owned Non-IMD Harris	-	-	-	-	-	-	0%	0%	-	-	-	-	-	-	-	1										
State-Owned Non-IMD MSRA Central	-	-	-	-	-	-	0%	0%	-	-	-	-	-	-	-	0										
Non-State-Owned Non-IMD MSRA Northeast	-	-	-	-	-	-	0%	0%	-	-	-	-	-	-	-	0										



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**From:** [Young, Gary \(HHSC\)](#)  
**To:** [CMS State Directed Payment](#); [Caruthers, Courtney \(HHSC\)](#); [Montalbano, Kathi \(HHSC\)](#)  
**Cc:** [Grady, Victoria C. \(HHSC\)](#); [HHSC TX Medicaid Waivers](#); [Giles, John \(CMS/CMCS\)](#); [Snyder, Laura M. \(CMS/CMCS\)](#); [Greenfield, Eli S. \(CMS/CMCS\)](#); [CMS MCOG DMCO Actions](#); [Jones, Angela F. \(CMS/CMCS\)](#); [Kristian, Diona \(CMS/CMCS\)](#); [Bilse, Brittani \(HHSC\)](#); [Zalkovsky, Emily \(HHSC\)](#); [Diseker, Sarah \(HHSC\)](#); [Loizias, Alexandra \(CMS/CMCS\)](#)  
**Subject:** Re: Texas SFY 2022 CHIRP Preprint for CMS  
**Date:** Thursday, July 8, 2021 5:10:06 PM

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Hi Juliet - Received thanks,

Gary

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**From:** CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>  
**Sent:** Thursday, July 8, 2021 11:31 AM  
**To:** Caruthers, Courtney (HHSC) <Courtney.Caruthers@hhs.texas.gov>; Montalbano, Kathi (HHSC) <Kathi.Montalbano@hhs.texas.gov>; Young, Gary (HHSC) <gary.young@hhs.texas.gov>  
**Cc:** Grady, Victoria C (HHSC) <Victoria.Grady@hhs.texas.gov>; HHSC TX Medicaid Waivers <TX\_Medicaid\_Waivers@hhs.texas.gov>; Giles, John (CMS/CMCS) <John.Giles1@cms.hhs.gov>; Snyder, Laura M. (CMS/CMCS) <Laura.Snyder1@cms.hhs.gov>; Greenfield, Eli S. (CMS/CMCS) <Eli.Greenfield@cms.hhs.gov>; CMS MCOG DMCO Actions <MCOGDMCOActions@cms.hhs.gov>; Jones, Angela F. (CMS/CMCS) <Angela.Jones2@cms.hhs.gov>; Kristian, Diona (CMS/CMCS) <Diona.Kristian@cms.hhs.gov>; Bilse, Brittani (HHSC) <Brittani.Bilse@hhs.texas.gov>; Zalkovsky, Emily (HHSC) <Emily.Zalkovsky@hhs.texas.gov>; Diseker, Sarah (HHSC) <Sarah.Diseker@hhs.texas.gov>; CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>; Loizias, Alexandra (CMS/CMCS) <Alexandra.Loizias@cms.hhs.gov>  
**Subject:** RE: Texas SFY 2022 CHIRP Preprint for CMS

Dear Texas team,

Attached are CMS' third round of questions on your CHIRP 438.6(c) state directed payment submission. Third round questions are highlighted in yellow and labeled as third round questions. If possible, please respond to this question set by **Monday, July 19th**. If you have any questions, etc., please let us know.

Sincerely,

Juliet

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**From:** Caruthers, Courtney (HHSC) <Courtney.Caruthers@hhs.texas.gov>  
**Sent:** Friday, June 11, 2021 1:03 PM  
**To:** CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>; Montalbano, Kathi (HHSC) <Kathi.Montalbano@hhs.texas.gov>; Young, Gary (HHSC) <gary.young@hhs.texas.gov>  
**Cc:** Grady, Victoria C (HHSC) <Victoria.Grady@hhs.texas.gov>; HHSC TX Medicaid Waivers <TX\_Medicaid\_Waivers@hhs.texas.gov>; Giles, John (CMS/CMCS) <john.giles1@cms.hhs.gov>; Snyder, Laura M. (CMS/CMCS) <Laura.Snyder1@cms.hhs.gov>; Kuhn, Juliet L. (CMS/CMCS) <Juliet.Kuhn@cms.hhs.gov>; Greenfield, Eli S. (CMS/CMCS) <Eli.Greenfield@cms.hhs.gov>; CMS MCOG DMCO Actions <MCOGDMCOActions@cms.hhs.gov>; Jones, Angela F. (CMS/CMCS) <Angela.Jones2@cms.hhs.gov>; Kristian, Diona (CMS/CMCS) <diona.kristian@cms.hhs.gov>; Bilse, Brittani (HHSC) <Brittani.Bilse@hhs.texas.gov>; Zalkovsky, Emily (HHSC) <Emily.Zalkovsky@hhs.texas.gov>; Diseker, Sarah (HHSC) <Sarah.Diseker@hhs.texas.gov>;

Caruthers,Courtney (HHSC) <Courtney.Caruthers@hhs.texas.gov>

**Subject:** RE: Texas SFY 2022 CHIRP Preprint for CMS

Good afternoon, please find attached the state's responses to the CHIRP round 2 questions, along a zipped file containing the complete CHIRP preprint packet for SFY 2022. Below we have noted if an attachment has been updated, or is new, since the initial preprint submission to CMS.

- CHIRP Preprint PDF: [The following updates were made to the preprint PDF:](#)
  - [Questions 4, 4a and 4b](#) – Updated the amounts to reflect the final rate increases.
  - [Question 6bi](#) – Updated the response to the rating periods previously approved by CMS. The initial preprint had SFY 2017-SFY 2021, but the correct rating periods are SFY 2018-SFY 2021.
  - [Question 19d](#) – Updated the response to reference new Attachment K.
  - [Question 42, Table 7](#) – Updated the response to reference new Attachment L.
- Attachment A – CHIRP Risk Group: [No changes.](#)
- Attachment B – CHIRP Preprint Question 8: [Updated the response as CMS requested in round 2 question 3a.](#)
- Attachment C – CHIRP Rate Estimates and Payment Levels: [The file contains the final rate increases, as well as two new tabs, "UPL Summary" and "CHIRP Payment Calc" which are referenced in the state's responses to the round 2 questions.](#)
- Attachment D – CHIRP Preprint Question 20c: [No changes.](#)
- Attachment E – IGT Entities: [The file was updated to reflect the IGT amounts received for the first half of the program year.](#)
- Attachment F – Local Provider Participation Funds: [No changes.](#)
- Attachment G – CHIRP Preprint Question 41: [No changes.](#)
- Attachment H – CHIRP Preprint Question 43 : [No changes.](#)
- Attachment I – CHIRP Evaluation Plan: [This is same revised evaluation plan HHSC submitted with its responses to the round 1 questions.](#)
- Attachment J – UHRIP Evaluation Report: [No changes.](#)
- Attachment K – Preprint Question 19d: [This is a new attachment and contains the updated response to preprint question 19d as CMS requested in round 2 question 5a.](#)

Attachment L – Preprint Question 42 Table 7: [This is a new attachment and contains the response to preprint question 42, Table 7 \(Quality Strategy Goals and Objectives\). The Table has the same updated goals and objectives the submitted with its responses to the round 1 questions.](#)

Thank you.

*Courtney Caruthers*

*1115 Waiver Specialist, Policy Development Support*

*Medicaid/CHIP*

*Health and Human Services Commission*

*Office 512-424-6514 \*currently working remotely*

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**From:** CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>

**Sent:** Friday, May 28, 2021 9:10 AM

**To:** Montalbano, Kathi (HHSC) <Kathi.Montalbano@hhs.texas.gov>; Young, Gary (HHSC) <gary.young@hhs.texas.gov>

**Cc:** Grady, Victoria C (HHSC) <Victoria.Grady@hhs.texas.gov>; Caruthers, Courtney (HHSC) <Courtney.Caruthers@hhs.texas.gov>; HHSC TX Medicaid Waivers <TX\_Medicaid\_Waivers@hhs.texas.gov>; Giles, John (CMS/CMCS) <John.Giles1@cms.hhs.gov>; Snyder, Laura M. (CMS/CMCS) <Laura.Snyder1@cms.hhs.gov>; Kuhn, Juliet L. (CMS/CMCS) <Juliet.Kuhn@cms.hhs.gov>; Greenfield, Eli S. (CMS/CMCS) <Eli.Greenfield@cms.hhs.gov>; CMS MCOG DMCO Actions <MCOGDMCOActions@cms.hhs.gov>; Jones, Angela F. (CMS/CMCS) <Angela.Jones2@cms.hhs.gov>; Kristian, Diona (CMS/CMCS) <Diona.Kristian@cms.hhs.gov>; Bilse, Brittani (HHSC) <Brittani.Bilse@hhs.texas.gov>; Zalkovsky, Emily (HHSC) <Emily.Zalkovsky@hhs.texas.gov>; CMS State Directed Payment <StateDirectedPayment@cms.hhs.gov>

**Subject:** RE: Texas SFY 2022 CHIRP Preprint for CMS

Hi Gary and Texas team,

Attached are CMS' second round of questions on your CHIRP 438.6(c) state directed payment submission. Second round questions are in green and labeled as second round questions.

If possible, please respond to this question set by Friday, June 11th. If you have any questions, etc., please let us know. We are actively reviewing the state's responses for the state's other 4 proposals and should have any additional questions on the QIPP responses ready for the state next.

Sincerely,

Laura

---

**From:** CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>

**Sent:** Thursday, May 6, 2021 8:51 AM

**To:** Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>

**Cc:** Grady, Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>; Caruthers, Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Giles, John (CMS/CMCS) <[john.giles1@cms.hhs.gov](mailto:john.giles1@cms.hhs.gov)>; Snyder, Laura M. (CMS/CMCS) <[Laura.Snyder1@cms.hhs.gov](mailto:Laura.Snyder1@cms.hhs.gov)>; Kuhn, Juliet L. (CMS/CMCS) <[Juliet.Kuhn@cms.hhs.gov](mailto:Juliet.Kuhn@cms.hhs.gov)>; Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>; CMS MCOG DMCO Actions <[MCOGDMCOActions@cms.hhs.gov](mailto:MCOGDMCOActions@cms.hhs.gov)>; Jones, Angela F. (CMS/CMCS) <[Angela.Jones2@cms.hhs.gov](mailto:Angela.Jones2@cms.hhs.gov)>; Kristian, Diona (CMS/CMCS) <[diona.kristian@cms.hhs.gov](mailto:diona.kristian@cms.hhs.gov)>; Bilse, Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>; Zalkovsky, Emily (HHSC) <[Emily.Zalkovsky@hhs.texas.gov](mailto:Emily.Zalkovsky@hhs.texas.gov)>; CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>

**Subject:** RE: Texas SFY 2022 CHIRP Preprint for CMS



Thank you Kathi, acknowledging receipt.

Juliet

---

**From:** Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>

**Sent:** Wednesday, May 5, 2021 5:18 PM

**To:** CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>; Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>

**Cc:** Grady, Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>; Caruthers, Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>; Snyder, Laura M. (CMS/CMCS) <[Laura.Snyder1@cms.hhs.gov](mailto:Laura.Snyder1@cms.hhs.gov)>; Kuhn, Juliet L. (CMS/CMCS) <[Juliet.Kuhn@cms.hhs.gov](mailto:Juliet.Kuhn@cms.hhs.gov)>; Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>; CMS MCOG DMCO Actions <[MCOGDMCOActions@cms.hhs.gov](mailto:MCOGDMCOActions@cms.hhs.gov)>; Jones, Angela F. (CMS/CMCS) <[Angela.Jones2@cms.hhs.gov](mailto:Angela.Jones2@cms.hhs.gov)>; Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>; Bilse, Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>; Zalkovsky, Emily (HHSC) <[Emily.Zalkovsky@hhs.texas.gov](mailto:Emily.Zalkovsky@hhs.texas.gov)>

**Subject:** RE: Texas SFY 2022 CHIRP Preprint for CMS

Good afternoon Juliet,

Please find the attached with HHSC's responses to the first round of questions on the CHIRP preprint for state fiscal year 2022. The attached includes:

- TX CHIRP Round 1 Question Set\_State responses\_final\_05.05.21
- CHIRP Round 1 State Responses\_ Attachment 1 (this attachment contains the additional exhibits requested by CMS and revised information for preprint questions 19b, 21, and 35a)
- CHIRP Round 1 State Responses\_ Attachment 2 - CHIRP Evaluation Plan Revision
- CHIRP Round 1 State Responses\_ Attachment 3 - Texas Medicaid Healthcare Quality Goals Guide 2021

Thanks.

*Kathi Montalbano*

Manager, Policy Development Support

Texas Health and Human Services Commission

Medicaid/CHIP Division

512-730-7409

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**From:** CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>

**Sent:** Wednesday, April 21, 2021 3:44 PM

**To:** Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>

**Cc:** Grady, Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>; Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers, Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; HHSC TX Medicaid Waivers

<[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>; Snyder, Laura M. (CMS/CMCS) <[Laura.Snyder1@cms.hhs.gov](mailto:Laura.Snyder1@cms.hhs.gov)>; Kuhn, Juliet L. (CMS/CMCS) <[Juliet.Kuhn@cms.hhs.gov](mailto:Juliet.Kuhn@cms.hhs.gov)>; Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>; CMS MCOG DMCO Actions <[MCOGDMCOActions@cms.hhs.gov](mailto:MCOGDMCOActions@cms.hhs.gov)>; Jones, Angela F. (CMS/CMCS) <[Angela.Jones2@cms.hhs.gov](mailto:Angela.Jones2@cms.hhs.gov)>; Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>; CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>

**Subject:** RE: Texas SFY 2022 CHIRP Preprint for CMS

Hi Gary and Texas team,

Attached is CMS' initial questions on your CHIRP 438.6(c) state directed payment submission. Our questions are geared to be sure that we understand the submission, and we are happy to setup a call with the state to walk through the questions if helpful.

If possible, please respond to this question set by Wednesday, May 5<sup>th</sup>. We recognize that there are a number of detailed questions; we are happy to work with the state on timelines for responses if May 5<sup>th</sup> is not possible. If you have any questions, etc., please let us know. We are actively working on the question sets for the state's other 4 proposals and should have the QIPP question set ready for the state next week.

Sincerely,

Juliet

---

**From:** CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>

**Sent:** Friday, March 19, 2021 11:19 AM

**To:** Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>

**Cc:** Grady, Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>; Montalbano, Kathi (HHSC)

<[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers, Courtney (HHSC)

<[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; HHSC TX Medicaid Waivers

<[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Giles, John (CMS/CMCS) <[john.giles1@cms.hhs.gov](mailto:john.giles1@cms.hhs.gov)>;

Snyder, Laura M. (CMS/CMCS) <[Laura.Snyder1@cms.hhs.gov](mailto:Laura.Snyder1@cms.hhs.gov)>; Kuhn, Juliet L. (CMS/CMCS)

<[Juliet.Kuhn@cms.hhs.gov](mailto:Juliet.Kuhn@cms.hhs.gov)>; CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>;

Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>; CMS MCOG DMCO Actions

<[MCOGDMCOActions@cms.hhs.gov](mailto:MCOGDMCOActions@cms.hhs.gov)>; Jones, Angela F. (CMS/CMCS) <[Angela.Jones2@cms.hhs.gov](mailto:Angela.Jones2@cms.hhs.gov)>

**Subject:** RE: Texas SFY 2022 CHIRP Preprint for CMS

Hi Gary – this email serves as confirmation that CHIRP preprint submission has been deemed complete by CMS. We will begin our formal review of the submission as discussed in STC 31.

Thank you,

Juliet

---

**From:** Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>

**Sent:** Thursday, March 18, 2021 9:54 AM

**To:** Grady, Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>; CMS State Directed Payment

<[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>

**Cc:** Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers, Courtney (HHSC)

<[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; HHSC TX Medicaid Waivers

<[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Giles, John (CMS/CMCS) <[john.giles1@cms.hhs.gov](mailto:john.giles1@cms.hhs.gov)>;

Snyder, Laura M. (CMS/CMCS) <[Laura.Snyder1@cms.hhs.gov](mailto:Laura.Snyder1@cms.hhs.gov)>; Kuhn, Juliet L. (CMS/CMCS)

<[Juliet.Kuhn@cms.hhs.gov](mailto:Juliet.Kuhn@cms.hhs.gov)>

**Subject:** Re: Texas SFY 2022 CHIRP Preprint for CMS

Yes. Confirmed.

**From:** Grady,Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>  
**Sent:** Thursday, March 18, 2021 8:51 AM  
**To:** CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>; Young,Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>  
**Cc:** Montalbano,Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers,Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>; Snyder, Laura M. (CMS/CMCS) <[Laura.Snyder1@cms.hhs.gov](mailto:Laura.Snyder1@cms.hhs.gov)>; Kuhn, Juliet L. (CMS/CMCS) <[Juliet.Kuhn@cms.hhs.gov](mailto:Juliet.Kuhn@cms.hhs.gov)>  
**Subject:** RE: Texas SFY 2022 CHIRP Preprint for CMS  
**Confirmed. Thank you!**  
VG

--

Victoria (Weber) Grady  
Director of Provider Finance  
C: (512) 431-7028

---

**From:** CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>  
**Sent:** Thursday, March 18, 2021 7:32 AM  
**To:** Young,Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>  
**Cc:** Grady,Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>; Montalbano,Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers,Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>; Snyder, Laura M. (CMS/CMCS) <[Laura.Snyder1@cms.hhs.gov](mailto:Laura.Snyder1@cms.hhs.gov)>; CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>; Kuhn, Juliet L. (CMS/CMCS) <[Juliet.Kuhn@cms.hhs.gov](mailto:Juliet.Kuhn@cms.hhs.gov)>  
**Subject:** RE: Texas SFY 2022 CHIRP Preprint for CMS

Thank you Gary. We are acknowledging receipt of the updated files and will review for completeness. We will follow-up by COB tomorrow (3/19) on the completeness of the submission. We understand that the state updated Attachment E to respond to all items requested in Table 4 and that this is the only revision to the preprint submission package. Can the state please confirm this?

Sincerely,  
Juliet

---

**From:** Young,Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>  
**Sent:** Wednesday, March 17, 2021 4:27 PM  
**To:** Kuhn, Juliet L. (CMS/CMCS) <[Juliet.Kuhn@cms.hhs.gov](mailto:Juliet.Kuhn@cms.hhs.gov)>; Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>; CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>  
**Cc:** Grady,Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>; Montalbano,Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers,Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>  
**Subject:** Texas SFY 2022 CHIRP Preprint for CMS

Juliet - In response to your March 11 email (below) HHSC is resubmitting a complete directed payment preprint packet for CHIRP, with modifications requested to Attachment E. to address Table 4.



We look forward to your confirmation that the preprint submission is complete.

Thank you,

Gary

**From:** Kuhn, Juliet L. (CMS/CMCS) <[Juliet.Kuhn@cms.hhs.gov](mailto:Juliet.Kuhn@cms.hhs.gov)>

**Sent:** Thursday, March 11, 2021 3:52 PM

**To:** Young, Gary (HHSC) <[gary.young@hhs.texas.gov](mailto:gary.young@hhs.texas.gov)>

**Cc:** Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers, Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; Grady, Victoria C (HHSC) <[Victoria.Grady@hhs.texas.gov](mailto:Victoria.Grady@hhs.texas.gov)>; HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Giles, John (CMS/CMCS) <[John.Giles1@cms.hhs.gov](mailto:John.Giles1@cms.hhs.gov)>; Snyder, Laura M. (CMS/CMCS) <[Laura.Snyder1@cms.hhs.gov](mailto:Laura.Snyder1@cms.hhs.gov)>; Burch Mack, Rebecca M. (CMS/CMCS) <[Rebecca.BurchMack@cms.hhs.gov](mailto:Rebecca.BurchMack@cms.hhs.gov)>; Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>; CMS MCOG DMCO Actions <[MCOGDMCOActions@cms.hhs.gov](mailto:MCOGDMCOActions@cms.hhs.gov)>; Jones, Angela F. (CMS/CMCS) <[Angela.Jones2@cms.hhs.gov](mailto:Angela.Jones2@cms.hhs.gov)>; CMS State Directed Payment <[StateDirectedPayment@cms.hhs.gov](mailto:StateDirectedPayment@cms.hhs.gov)>; Kuhn, Juliet L. (CMS/CMCS) <[Juliet.Kuhn@cms.hhs.gov](mailto:Juliet.Kuhn@cms.hhs.gov)>

**Subject:** RE: Texas SFY 2022 CHIRP Preprint for CMS

**WARNING:** This email is from outside the HHS system. Do not click on links or attachments unless you expect them from the sender and know the content is safe.

Dear Gary,

Thank you for your submission of a state directed payment preprint under 42 C.F.R. § 438.6(c). We reviewed the submission for completeness and determined the submission to be incomplete. To be considered complete, CMS needs the information that is requested under Table 4 in preprint question 35 specific to IGT Transferring Entities. Attachment E provided by the state includes the names of the transferring entities but does not address the other fields in Table 4 of the preprint. We understand that the collection of IGTs for the program year has not commenced and the state may not have final IGT submission information at this time. However, CMS believes some estimated detail is necessary as we cannot begin review of a preprint with key components of the preprint not completed. We request that the state provide whatever is known at this time related to each entity's operational nature, estimated total dollar amounts to be transferred (which may not be final), and if the entity has general taxing authority, receives appropriations, and is eligible to receive payments under this state directed payment.

As CMS does not believe the state has submitted a complete preprint, the timeframes outlined in the Special Terms and Conditions (STCs) of the [approved 1115 demonstration](#) have not commenced. For example, within STC 31, CMS is required to furnish to Texas all requests for information needed to assist CMS in evaluating the request within 30 calendar days following receipt of the complete request for approval from the state. CMS does not believe the state has met the threshold of submitting a "complete request for approval" as you have not completed each question on the preprint form states must utilize to request approval for a state directed payment.

Once CMS receives a revised preprint that meets our expectations outlined above and is deemed complete by CMS, CMS will initiate its formal review process of the complete state directed payment preprint submission as discussed in STC 31.

In the interim, CMS would be happy to schedule a call with the state as requested to discuss the incomplete proposal. The following are some dates and times that CMS is available for a call:

3/23: 12-1pm, 2:30-3pm, 4-5pm ET

3/24: 1-2pm ET

3/25: 12-1pm, 1-2pm, 4-5pm ET

3/28: 9-10am, 11-12pm, 1-5pm ET

Please reach out with any questions, concerns, etc., and we look forward to working with Texas on this state directed payment submission.

Thank you,

Juliet

---

**F**

**From:** [Montalbano, Kathi \(HHSC\)](#)  
**To:** [Kristian, Diona \(CMS/CMCS\)](#); [HHSC TX Medicaid Waivers](#); [Greenfield, Eli S. \(CMS/CMCS\)](#); [Blunt, Ford J. \(CMS/CMCS\)](#)  
**Cc:** [Caruthers, Courtney \(HHSC\)](#); [Bilse, Brittani \(HHSC\)](#)  
**Subject:** RE: STAR+PLUS Pilot Program CMS Questions  
**Date:** Thursday, July 8, 2021 10:17:44 AM  
**Attachments:** [image001.png](#)

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Diona,

We are checking on our end and will get back to you. Thanks.

*Kathi Montalbano*  
Manager, Policy Development Support  
Texas Health and Human Services Commission  
Medicaid/CHIP Division  
512-730-7409

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---

**From:** Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>  
**Sent:** Thursday, July 8, 2021 9:04 AM  
**To:** HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>; Blunt, Ford J. (CMS/CMCS) <[Ford.Blunt@cms.hhs.gov](mailto:Ford.Blunt@cms.hhs.gov)>  
**Cc:** Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers, Courtney (HHSC) <[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; Bilse, Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>  
**Subject:** RE: STAR+PLUS Pilot Program CMS Questions

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Hello Basundhara,

Is the Texas team available on Thursday, July 15 11:00 ET / 10:00 CT to meet for this technical assistance call?

Thanks,  
Diona

---

**From:** HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>  
**Sent:** Thursday, June 17, 2021 3:20 PM  
**To:** Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>; Greenfield, Eli S. (CMS/CMCS)

<[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>; Blunt, Ford J. (CMS/CMCS) <[Ford.Blunt@cms.hhs.gov](mailto:Ford.Blunt@cms.hhs.gov)>

**Cc:** Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Caruthers, Courtney (HHSC)

<[Courtney.Caruthers@hhs.texas.gov](mailto:Courtney.Caruthers@hhs.texas.gov)>; Bilse, Brittani (HHSC) <[Brittani.Bilse@hhs.texas.gov](mailto:Brittani.Bilse@hhs.texas.gov)>

**Subject:** STAR+PLUS Pilot Program CMS Questions

Good Afternoon,

Please find attached for consideration the SP3 questions and attachments as requested during the monitoring call on May 27, 2021. Questions 1 and 2 were previously submitted to CMS. Question 3 has been added for consideration.

Thanks,

*Basundhara Raychaudhuri*

1115 Waiver Coordinator  
Office of Policy and Programs  
Medicaid and CHIP Services  
Phone: 512-487-3318



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**From:** [HHSC TX Medicaid Waivers](#)  
**To:** [Devoid, Isaac \(CMS/CMCS\)](#); [Blunt, Ford J. \(CMS/CMCS\)](#); [Kristian, Diona \(CMS/CMCS\)](#); [Greenfield, Eli S. \(CMS/CMCS\)](#)  
**Cc:** [Montalbano, Kathi \(HHSC\)](#); [Kazi, Paula \(CMS/CMCS\)](#)  
**Subject:** RE: Follow up CMS call on Eval design  
**Date:** Wednesday, July 7, 2021 2:37:56 PM  
**Attachments:** [image001.png](#)

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Good Afternoon Isaac,  
For this call State would like to focus the discussion on the Star Kids evaluation options. Please let us know if you have question.  
Thanks,

*Basundhara Raychaudhuri*

1115 Waiver Coordinator  
Office of Policy and Programs  
Medicaid and CHIP Services  
Phone: 512-487-3318



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**From:** Devoid, Isaac (CMS/CMCS) <Isaac.Devoid@cms.hhs.gov>  
**Sent:** Tuesday, June 29, 2021 11:46 AM  
**To:** HHSC TX Medicaid Waivers <TX\_Medicaid\_Waivers@hhs.texas.gov>; Blunt, Ford J. (CMS/CMCS) <Ford.Blunt@cms.hhs.gov>; Kristian, Diona (CMS/CMCS) <Diona.Kristian@cms.hhs.gov>; Greenfield, Eli S. (CMS/CMCS) <Eli.Greenfield@cms.hhs.gov>  
**Cc:** Montalbano, Kathi (HHSC) <Kathi.Montalbano@hhs.texas.gov>; Kazi, Paula (CMS/CMCS) <Paula.Kazi@cms.hhs.gov>  
**Subject:** RE: Follow up CMS call on Eval design

Thank you so much for confirming. I will send out a meeting invite shortly.

Can you please send over the list of attendees from Texas?

Thanks, and all the best,

Isaac

---

**From:** HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>  
**Sent:** Monday, June 28, 2021 10:04 AM  
**To:** Devoid, Isaac (CMS/CMCS) <[Isaac.Devoid@cms.hhs.gov](mailto:Isaac.Devoid@cms.hhs.gov)>; Blunt, Ford J. (CMS/CMCS) <[Ford.Blunt@cms.hhs.gov](mailto:Ford.Blunt@cms.hhs.gov)>; Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>; Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>  
**Cc:** Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Kazi, Paula (CMS/CMCS) <[Paula.Kazi@cms.hhs.gov](mailto:Paula.Kazi@cms.hhs.gov)>  
**Subject:** RE: Follow up CMS call on Eval design

Good Morning Isaac,  
Yes we can meet on 23<sup>rd</sup> July 12.30-1.30pm CST .  
Thanks,

Basundhara Raychaudhuri  
1115 Waiver Coordinator  
Office of Policy and Programs  
Medicaid and CHIP Services  
Phone: 512-487-3318



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---

**From:** Devoid, Isaac (CMS/CMCS) <[Isaac.Devoid@cms.hhs.gov](mailto:Isaac.Devoid@cms.hhs.gov)>  
**Sent:** Monday, June 28, 2021 6:34 AM  
**To:** HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>; Blunt, Ford J. (CMS/CMCS) <[Ford.Blunt@cms.hhs.gov](mailto:Ford.Blunt@cms.hhs.gov)>; Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>; Greenfield, Eli S. (CMS/CMCS) <[Eli.Greenfield@cms.hhs.gov](mailto:Eli.Greenfield@cms.hhs.gov)>  
**Cc:** Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>; Kazi, Paula (CMS/CMCS) <[Paula.Kazi@cms.hhs.gov](mailto:Paula.Kazi@cms.hhs.gov)>  
**Subject:** RE: Follow up CMS call on Eval design

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Good morning,

If possible, could we meet on July 23<sup>rd</sup>, 12:30-1:30pm CST?

Thanks, and have a great week,

Isaac

---

**From:** HHSC TX Medicaid Waivers <[TX\\_Medicaid\\_Waivers@hhs.texas.gov](mailto:TX_Medicaid_Waivers@hhs.texas.gov)>  
**Sent:** Friday, June 25, 2021 11:11 AM  
**To:** Blunt, Ford J. (CMS/CMCS) <[Ford.Blunt@cms.hhs.gov](mailto:Ford.Blunt@cms.hhs.gov)>; Kristian, Diona (CMS/CMCS) <[Diona.Kristian@cms.hhs.gov](mailto:Diona.Kristian@cms.hhs.gov)>; Devoid, Isaac (CMS/CMCS) <[Isaac.Devoid@cms.hhs.gov](mailto:Isaac.Devoid@cms.hhs.gov)>  
**Cc:** Montalbano, Kathi (HHSC) <[Kathi.Montalbano@hhs.texas.gov](mailto:Kathi.Montalbano@hhs.texas.gov)>  
**Subject:** Follow up CMS call on Eval design

Good Morning,

As discussed during yesterday's 1115 monthly call please find below the State's proposed date and time to meet with CMS to discuss Eval design .

22<sup>nd</sup> July 2.30-3.30pm CST  
23<sup>rd</sup> July 12.30-1.30pm CST  
26<sup>th</sup> July 11.30-12.30pm CST

Let us know which one works for CMS.

Thanks,

*Basundhara Raychaudhuri*

1115 Waiver Coordinator  
Office of Policy and Programs  
Medicaid and CHIP Services  
Phone: 512-487-3318



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*all copies of the original message.*



**From:** [HHSC TX Medicaid Waivers](#)  
**To:** [Kristian, Diona \(CMS/CMCS\)](#); [Greenfield, Eli S. \(CMS/CMCS\)](#); [Blunt, Ford J. \(CMS/CMCS\)](#)  
**Cc:** [Montalbano, Kathi \(HHSC\)](#); [Caruthers, Courtney \(HHSC\)](#)  
**Subject:** Q1/Q2 monitoring report/Semiannual monitoring report  
**Date:** Tuesday, July 6, 2021 6:39:43 PM  
**Attachments:** [image001.png](#)  
[All Attachments for CMS Q1 Q2 DY10 final.zip](#)  
[1115 waiver monitoring report Q1 Q2 DY 10 2021 FINAL.docx](#)

---

Good Evening Diona,

Attached is a copy of the combined quarter one and quarter two 1115 monitoring report (as required by STC 74 in the STCs approved January 15, 2021) and the semiannual monitoring report (as required by STC 60 in the STCs approved October 13, 2020). The report was also uploaded to the PMDA system today.

Thanks,

*Basundhara Raychaudhuri*

1115 Waiver Coordinator  
Office of Policy and Programs  
Medicaid and CHIP Services  
Phone: 512-487-3318



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## Managed Care Plans by Service Area SFY21

Service Area	STAR	STAR+PLUS	STAR Kids
<b>Bexar</b>	Aetna Better Health	Amerigroup	Community First Health Plans
	Amerigroup	Molina Healthcare of Texas	Superior HealthPlan
	Community First Health Plans	Superior HealthPlan	
	Superior HealthPlan		
<b>Dallas</b>	Amerigroup	Molina Healthcare of Texas	Amerigroup
	Molina Healthcare of Texas	Superior HealthPlan	Aetna Better Health
	Parkland Community Health Plan		
<b>El Paso</b>	El Paso Health	Amerigroup	Amerigroup
	Molina Healthcare of Texas	Molina Healthcare of Texas	Superior HealthPlan
	Superior HealthPlan		
<b>Harris</b>	Amerigroup	Amerigroup	Amerigroup
	Community Health Choice	Molina Healthcare of Texas	Texas Children's Health Plan
	Molina Healthcare of Texas	UnitedHealthcare Community Plan	UnitedHealthcare Community Plan
	Texas Children's Health Plan		
<b>Hidalgo</b>	UnitedHealthcare Community Plan		
	Driscoll Children's Health Plan	Cigna-HealthSpring	Driscoll Health Plan
	Molina Healthcare of Texas	Molina Healthcare of Texas	Superior HealthPlan
	Superior HealthPlan	Superior HealthPlan	UnitedHealthcare Community Plan
<b>Jefferson</b>	UnitedHealthcare Community Plan		
	Amerigroup	Amerigroup	Texas Children's Health Plan
	Community Health Choice	Molina Healthcare of Texas	UnitedHealthcare Community Plan
	Molina Healthcare of Texas	UnitedHealthcare Community Plan	
<b>Lubbock</b>	Texas Children's Health Plan		
	UnitedHealthcare Community Plan		
	Amerigroup	Amerigroup	Amerigroup
	FirstCare Health Plans	Superior HealthPlan	Superior HealthPlan
<b>MRSA Central</b>	Superior HealthPlan		
	Amerigroup	Superior HealthPlan	Blue Cross Blue Shield of Texas
	Right Care from Scott & White	UnitedHealthcare Community Plan	UnitedHealthcare Community Plan
<b>MRSA Northeast</b>	Superior HealthPlan		
	Amerigroup	Cigna-HealthSpring	Texas Children's Health Plan
	Superior HealthPlan	UnitedHealthcare Community Plan	UnitedHealthcare Community Plan
<b>MRSA West</b>	Amerigroup	Amerigroup	Amerigroup
	FirstCare Health Plans	Superior HealthPlan	Superior HealthPlan
	Superior HealthPlan		
<b>Nueces</b>	Driscoll Health Plan	Superior HealthPlan	Driscoll Health Plan
	Superior HealthPlan	UnitedHealthcare Community Plan	Superior HealthPlan
	UnitedHealthcare Community Plan		
<b>Tarrant</b>	Aetna Better Health	Amerigroup	Aetna Better Health
	Amerigroup	Cigna-HealthSpring	Cook Children's Health Plan
	Cook Children's Health Plan		
<b>Travis</b>	Blue Cross Blue Shield of Texas	Amerigroup	Blue Cross Blue Shield of Texas
	Dell Children's Medical Center	UnitedHealthcare Community Plan	Superior HealthPlan
	Superior HealthPlan		
<b>Statewide</b>	DentaQuest USA Insurance Company, Inc.		
	MCNA Insurance Company		
	United HealthCare Dental		

**Attachment B1**  
**Enrollment Summary SFY21**

Program	SDA	MCO	Q1	Market Share	Q2	Market Share	% Change Between Quarter 1 & 2
Dental	Statewide	DentaQuest	2,072,438	58%	2,111,456	57%	1.88%
		MCNA	1,447,755	40%	1,449,706	39%	0.13%
		United	83,421	2%	145,847	4%	74.83%
Dental Total			3,603,614	100%	3,707,009	100%	2.87%
STAR	Bexar	Aetna	25,395	1%	27,808	1%	9.50%
		Amerigroup	11,895	0%	12,708	0%	6.83%
		Community First	126,019	4%	133,793	4%	6.17%
		Superior	143,422	4%	148,935	4%	3.84%
	Dallas	Amerigroup	242,961	7%	257,741	7%	6.08%
		Molina	33,779	1%	35,740	1%	5.81%
		Parkland	179,021	5%	188,419	5%	5.25%
	El Paso	El Paso First	74,918	2%	78,748	2%	5.11%
		Molina	4,077	0%	4,387	0%	7.60%
		Superior	54,685	2%	56,644	2%	3.58%
	Harris	Amerigroup	95,302	3%	99,236	3%	4.13%
		CHC	273,081	8%	288,650	8%	5.70%
		Molina	12,840	0%	13,502	0%	5.16%
		Texas Children's	377,684	11%	398,038	11%	5.39%
	Hidalgo	United	87,131	3%	95,776	3%	9.92%
		Driscoll Children's	113,552	3%	119,453	3%	5.20%
		Molina	49,404	1%	51,050	1%	3.33%
		Superior	162,451	5%	168,946	5%	4.00%
	Jefferson	United	63,200	2%	64,891	2%	2.68%
		Amerigroup	8,466	0%	8,947	0%	5.68%
		CHC	25,542	1%	26,718	1%	4.60%
		Molina	4,680	0%	4,845	0%	3.53%
		Texas Children's	37,562	1%	40,218	1%	7.07%
	Lubbock	United	21,415	1%	22,765	1%	6.30%
		Amerigroup	11,286	0%	11,840	0%	4.91%
		FirstCare	38,818	1%	40,811	1%	5.13%
		Superior	39,492	1%	41,779	1%	5.79%
	MRSA Central	Amerigroup	22,687	1%	23,753	1%	4.70%
		Scott & White	49,954	1%	52,264	1%	4.62%
		Superior	92,894	3%	98,167	3%	5.68%
	MRSA Northeast	Amerigroup	74,799	2%	80,196	2%	7.22%
		Superior	126,884	4%	132,964	4%	4.79%
	MRSA West	Amerigroup	40,210	1%	42,817	1%	6.48%
		FirstCare	45,979	1%	48,836	1%	6.21%
		Superior	99,675	3%	105,542	3%	5.89%
	Nueces	Driscoll Children's	76,480	2%	80,042	2%	4.66%
		Superior	23,270	1%	24,322	1%	4.52%
		United	3,549	0%	3,717	0%	4.73%
	Tarrant	Aetna	61,328	2%	66,428	2%	8.32%
		Amerigroup	137,377	4%	145,708	4%	6.06%
		Cook Children's	124,236	4%	131,469	4%	5.82%
	Travis	BCBS	41,386	1%	44,227	1%	6.86%
		DELL	30,348	1%	33,025	1%	8.82%
		Superior	104,373	3%	109,469	3%	4.88%
STAR Total			3,473,507	83%	3,665,334	84%	5.52%
STAR Kids	Bexar	Community First	7,780	5%	7,953	5%	2.22%
		Superior	6,961	4%	7,063	4%	1.47%
	Dallas	Aetna	7,406	74%	7,438	4%	0.43%
		Amerigroup	15,069	9%	15,542	9%	3.14%
		Children's Medical Center	3	0%		0%	-100.00%

**Attachment B1**  
**Enrollment Summary SFY21**

Program	SDA	MCO	Q1	Market Share	Q2	Market Share	% Change Between Quarter 1 & 2
	El Paso	Amerigroup	1,441	1%	1,480	1%	2.71%
		Superior	3,604	2%	3,674	2%	1.94%
	Harris	Amerigroup	7,384	4%	7,561	4%	2.40%
		Texas Children's	21,594	13%	21,969	13%	1.74%
		United	10,139	6%	10,378	6%	2.36%
	Hidalgo	Driscoll Children's	6,495	4%	6,588	4%	1.43%
		Superior	9,027	5%	9,196	5%	1.87%
		United	6,973	4%	6,992	4%	0.27%
	Jefferson	Texas Children's	2,701	2%	2,785	2%	3.11%
		United	2,421	1%	2,441	1%	0.83%
	Lubbock	Amerigroup	1,567	1%	1,596	1%	1.85%
		Superior	1,929	1%	1,970	1%	2.13%
	MRSA Central	BCBS	4,574	3%	4,684	3%	2.40%
		United	4,862	3%	4,936	3%	1.52%
	MRSA Northeast	Texas Children's	5,336	3%	5,515	3%	3.35%
		United	5,822	3%	5,898	3%	1.31%
	MRSA West	Amerigroup	3,270	2%	3,323	2%	1.62%
		Superior	3,774	2%	3,868	2%	2.49%
	Nueces	Driscoll Children's	4,094	2%	4,138	2%	1.07%
		Superior	1,350	1%	1,364	1%	1.04%
	Tarrant	Aetna	5,114	3%	5,371	3%	5.03%
		Cook Children's	10,025	6%	10,145	6%	1.20%
	Travis	BCBS	4,018	2%	4,129	2%	2.76%
		Superior	3,663	2%	3,750	2%	2.38%
STAR Kids Total			168,396	4%	171,747	4%	2%
STAR+PLUS	Bexar	Amerigroup	9,979	2%	9,940	2%	-0.39%
		Molina	7,837	1%	7,724	1%	-1.44%
		Superior	29,041	5%	28,761	5%	-0.96%
	Dallas	Molina	36,363	7%	35,865	7%	-1.37%
		Superior	27,272	5%	26,929	5%	-1.26%
	El Paso	Amerigroup	11,402	2%	11,287	2%	-1.01%
		Molina	10,196	2%	10,032	2%	-1.61%
	Harris	Amerigroup	38,861	7%	38,747	7%	-0.29%
		Molina	11,930	2%	11,633	2%	-2.49%
		United	57,182	11%	56,945	11%	-0.41%
	Hidalgo	Cigna-HealthSpring	15,907	3%	15,688	3%	-1.38%
		Molina	14,241	3%	14,085	3%	-1.10%
		Superior	31,857	6%	31,504	6%	-1.11%
	Jefferson	Amerigroup	6,027	1%	5,971	1%	-0.93%
		Molina	5,728	1%	5,619	1%	-1.90%
		United	7,510	1%	7,652	1%	1.89%
	Lubbock	Amerigroup	6,409	1%	6,320	1%	-1.39%
		Superior	7,073	1%	6,963	1%	-1.56%
	MRSA Central	Superior	15,992	3%	16,006	3%	0.09%
		United	14,797	3%	14,773	3%	-0.16%
	MRSA Northeast	Cigna-HealthSpring	20,623	4%	20,396	4%	-1.10%
		United	25,285	5%	25,255	5%	-0.12%
	MRSA West	Amerigroup	16,131	3%	15,896	3%	-1.46%
		Superior	20,380	4%	20,132	4%	-1.22%
	Nueces	Superior	10,449	2%	10,414	2%	-0.33%
		United	10,242	2%	10,263	2%	0.21%
	Tarrant	Amerigroup	30,635	6%	30,274	6%	-1.18%
		Cigna-HealthSpring	11,642	2%	11,551	2%	-0.78%
	Travis	Amerigroup	11,005	2%	10,887	2%	-1.07%

**Attachment B1**  
**Enrollment Summary SFY21**

Program	SDA	MCO	Q1	Market Share	Q2	Market Share	% Change Between Quarter 1 & 2
	Travis	United	15,201	3%	15,298	3%	0.64%
STAR PLUS Total			537,197	13%	532,810	12%	-0.82%
STAR, STAR Kids, and STAR+PLUS Total			4,179,100	100%	4,369,891	100%	4.57%

**Disenrollment Summary SFY21**  
(Blanks = No Disenrollment During Quarter)

Program/MCO/Issue	Quarter 1	Quarter 2	Total
<b>STAR</b>			
<b>Aetna</b>			
DISENROLLMENT REQUEST DENIED	1		
<b>Amerigroup Texas, Inc.</b>			
MEMBER REQUESTED DISENROLLMENT		1	
<b>Community Health Choice</b>			
MCO REQUESTED DISENROLLMENT	1		
<b>STAR Total</b>	<b>2</b>	<b>1</b>	<b>0</b>
<b>STAR+PLUS</b>			
<b>Molina Healthcare of Texas</b>			
DISENROLLMENT REQUEST DENIED	1		
<b>Superior HealthPlan</b>			
MEMBER REQUESTED DISENROLLMENT		1	
<b>STAR+PLUS Total</b>	<b>1</b>	<b>1</b>	<b>0</b>
<b>STAR Kids Total</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Dental Total</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Grand Total</b>	<b>3</b>	<b>2</b>	<b>5</b>

## **Attachment C1**

### **Provider Network Count Methodology - FY21**

#### **PROVIDER TYPES**

Primary care provider (PCP) and specialist counts are based on the provider network files submitted by MCOs. The data is validated using the Medicaid Master Provider File. Unique provider counts are generated using the National Provider Identifiers (NPIs). The NPI is the standard unique identifier for health-care providers, and is required to enroll as a Texas Medicaid provider. The provider count data represents a snapshot in time and shows the number of unique providers for the last month of the quarter.

HHSC reporting requirements for the MCOs restricts PCP validity to certain provider specialty codes. The network counts are based on all PCPs with open panel included in the MCO provider files, which includes traditional and non-traditional provider types listed in Appendix A, as well as other provider types that may have agreed to serve as a PCP for a particular member with special needs.

The specialist count includes all specialty provider types listed in Appendix B. Since a provider may be represented in both the PCP count and Specialist count, the combined total may include duplications.

Dental provider counts are broken down by main dentists and dental specialists. For DMOs, the PCP column shows the number of main dentists (general or pediatric) with open panel. The specialist column includes endodontists, oral surgeon, orthodontists, pediatric dental, periodontist, and prosthodontists.

Pharmacy counts include the following pharmacy providers: pharmacy, 24 Hour Pharmacy, and Mail Order Pharmacy.

#### **PROVIDER TERMINATIONS**

PCP and Specialists terminations counts are based on self-reported data from the MCOs. The MCOs reported a variety of reasons for provider termination, including providers failed to re-credential, termination requested by provider, MCO terminated for cause, provider left group practice, and provider retired and provider closed practice.

**Attachment C1****Provider Network Count Methodology - FY21****APPENDIX A: PRIMARY CARE PROVIDER TYPES**

- Cardiovascular Disease\*
- Certified Nurse Specialist
- E.E.N.T. (D.O.)\*
- Family Practice/General Practice
- Federally Qualified Health Center
- Gastroenterology\*
- Geriatrics
- Gynecology
- Internal Medicine
- Multispecialty Clinic
- Neurology (M.D.)\*
- Neurosurgery\*
- Nuclear Medicine\*
- Nurse Midwife
- Nurse Practitioner
- OB/GYN (D.O., M.D.)
- Orthopedic Surgery\*
- Otorhinolaryngology (E.N.T)\*
- Pediatrics
- Physician (D.O., M.D.)
- Physician Group (D.O., M.D.)
- Rural Health Clinic (Independent, Provider)
- Urology\*

Note: Provider types with an asterisk (\*) are valid PCPs for members with special needs.



## **Attachment C1**

### **Provider Network Count Methodology - FY21**

#### **APPENDIX B: SPECIALIST TYPES**

- Ambulance Service
- Ambulatory Surgical Services
- Audiologist
- Birthing Center
- Case Management - Mental Health 'MH'/Mental Health Rehab "MHR"
- Case Management - Mental Retardation 'MR'
- CCP Provider
- Certified Nurse Specialist
- Certified Registered Nurse Anesthetist (CRNA)
- Children's Hospital
- Chiropractic
- CIDC Reserved for Future Use
- Consumer Directed Services (CDS)
- Dentist/Orthodontists (D.M.D., D.D.S.)
- E.E.N.T. (D.O.)
- EPSDT - Texas Health Steps
- EPSDT - Texas Health Steps Health DPT Mobile Units & Regional
- Family Planning Agency (Public Health)
- Freestanding Psychiatric Hospital
- Freestanding Rehabilitation Facility
- Freestanding Renal Dialysis Facility
- Gastroenterology
- Genetics
- Geriatrics
- Hand Surgery
- Home Health Agency
- Home Health DME
- Hospice
- Hospital - Long Term or Specialized Care
- Hospital - Nonprofit/Acute/101-250 Beds
- Hospital - Nonprofit/Acute/1-50 Beds
- Hospital - Nonprofit/Acute/251 Plus Beds
- Hospital - Nonprofit/Acute/51-100 Beds
- Hospital - Other/Out-of-State
- Hospital - Profit/Acute/101 Plus Beds
- Hospital - Profit/Acute/1-50 Beds
- Hospital - Profit/Acute/51-100 Beds

## **Attachment C1**

### **Provider Network Count Methodology - FY21**

- Hospital - Teaching Affiliate
- In- Home Hyperalimentation Supplies
- Independent Laboratory
- Individual Certified Orthodontist
- Individual Certified Prosthetist
- Individual Physical Therapist
- Internal Medicine
- Licensed Professional Counselor (CCP)
- (LMSW-ACP) LIC MSTR Social WRKR/ADV Clinical Pract
- Manipulative Therapy(D.O.)
- Maternity Service Clinic
- Medical Supply Company with Certified Prosthetist
- Multispecialty Clinic
- Nephrology
- Neurology (M.D.)
- Neurosurgery
- Nuclear Medicine
- Nurse Practitioner
- Nurse/Nurse Midwife
- Nursing Home
- OB/GYN (D.O.)
- OB/GYN (M.D.)
- Ophthalmology
- Optometrist
- Orthopedic Surgery
- Pathology (D.O.)
- Pathology (M.D.)
- Pediatrics
- Peripheral Vascular Disease
- Personal Care Services (PCS)
- Physical Medicine and Rehabilitation
- Plastic Surgery
- Podiatry
- Portable X-Ray Supplier
- Proctology
- Psychiatric Hospital
- Psychiatric Hospital Medicare Crossovers Only
- Psychiatry
- Psychiatry (D.O.)

## **Attachment C1**

### **Provider Network Count Methodology - FY21**

- Psychologist
- Pulmonary Disease
- Radiation Therapy
- Radiation Treatment Center
- Radiology (D.O.)
- Radiology (M.D.)
- Registered Nurse (CCP)
- Rural Health Clinic (Independent)
- Rural Health Clinic (Provider)
- Seating Clinic
- Social Worker (CCP)
- Speech Therapy (CCP)
- State Hospital Physician Groups
- Tape-to-Tape
- Texas Commission for the Blind (TCB)
- Texas Health Steps Case Management
- Thoracic Surgery
- Tuberculosis (TB) Clinics
- Urology

**Attachment C2**  
**Provider Network Counts**  
**SFY21**

Program	Primary Care Provider	Specialist	Dentist	Pharmacist	Unique NPI Total
<b>Quarter 1</b>					
Dental (statewide)	48	13	6,090		6,138
STAR	17,145	72,092	3,542	5,089	85,471
STAR+PLUS	15,648	67,382	3,837	4,930	79,758
STAR Kids	15,415	60,177	125	5,332	70,818
Total	20,291	79,501	6,531	5,370	94,498
<b>Quarter 2</b>					
Dental (statewide)	54	12	6,267		6,322
STAR	17,290	75,669	3,583	5,020	87,855
STAR+PLUS	15,871	69,140	3,880	4,856	80,754
STAR Kids	15,655	61,006	125	5,301	71,843
Total	20,453	82,178	6,611	5,333	96,275

**Primary Care Physicians Terminated SFY21**

**Blanks = No Data Available**

Program/MCO/SDA	Quarter 1	Quarter 2
<b>Medicaid Dental</b>		
DentaQuest	358	391
MCNA	139	162
UnitedHealthCare Dental	54	27
<b>Medicaid Dental</b>	<b>551</b>	<b>580</b>
<b>STAR</b>		
<b>Aetna</b>		
Bexar	6	13
Tarrant	27	6
Subtotal	33	19
<b>Amerigroup</b>		
Bexar	3	9
Dallas	30	40
Harris	22	39
Jefferson	5	0
Lubbock	0	1
MRSA Central	4	2
MRSA Northeast	15	13
MRSA West	31	9
Tarrant	22	12
Subtotal	132	125
<b>BCBS</b>		
Travis		20
Subtotal		20
<b>CHC</b>		
Harris	88	94
Jefferson	5	2
Subtotal	93	96
<b>Community First</b>		
Bexar	21	7
Subtotal	21	7
<b>Cook Children's</b>		
Tarrant	23	6
Subtotal	23	6
<b>DELL</b>		
Travis	22	10
Subtotal	22	10
<b>Driscoll Children's</b>		
Hidalgo	9	14

**Attachment C3****Primary Care Physicians Terminated SFY21****Blanks = No Data Available**

Nueces	2	3
<b>Subtotal</b>	<b>11</b>	<b>17</b>
<b>El Paso First</b>		
El Paso	7	7
<b>Subtotal</b>	<b>7</b>	<b>7</b>
<b>FirstCare</b>		
Lubbock	0	0
MRSA West	0	1
<b>Subtotal</b>	<b>0</b>	<b>1</b>
<b>Molina</b>		
Dallas	39	44
El Paso	29	18
Harris	45	167
Hidalgo	26	25
Jefferson	39	169
<b>Subtotal</b>	<b>178</b>	<b>423</b>
<b>Parkland</b>		
Dallas	7	1
<b>Subtotal</b>	<b>7</b>	<b>1</b>
<b>Scott &amp; White</b>		
MRSA Central	18	6
<b>Subtotal</b>	<b>18</b>	<b>6</b>
<b>Superior</b>		
Bexar	68	86
El Paso	27	15
Hidalgo	57	31
Lubbock	44	18
MRSA Central	57	50
MRSA Northeast	74	39
MRSA West	65	80
Nueces	16	10
Travis	63	53
<b>Subtotal</b>	<b>471</b>	<b>382</b>
<b>Texas Children's</b>		
Harris	1	15
Jefferson	0	1
<b>Subtotal</b>	<b>1</b>	<b>16</b>
<b>United</b>		
Harris	58	38
Hidalgo	8	5

**Primary Care Physicians Terminated SFY21**

**Blanks = No Data Available**

Jefferson	53	33
Nueces	1	0
Subtotal	120	76
<b>STAR</b>	<b>1,137</b>	<b>1,212</b>
<b>STAR Kids</b>		
<b>Aetna</b>		
Dallas	27	11
Tarrant	32	13
Subtotal	59	24
<b>Amerigroup</b>		
Dallas	31	39
El Paso	5	2
Harris	21	41
Lubbock	0	1
MRSA West	20	8
Subtotal	77	91
<b>BCBS</b>		
MRSA Central		50
Travis		50
Subtotal		100
<b>Community First</b>		
Bexar	21	7
Subtotal	21	7
<b>Cook Children's</b>		
Tarrant	21	5
Subtotal	21	5
<b>Driscoll Children's</b>		
Hidalgo	9	14
Nueces	2	3
Subtotal	11	17
<b>Superior</b>		
Bexar	36	42
El Paso	10	13
Hidalgo	15	17
Lubbock	19	15
MRSA West	18	64
Nueces	3	3
Travis	34	19
Subtotal	135	173
<b>Texas Children's</b>		

**Attachment C3****Primary Care Physicians Terminated SFY21****Blanks = No Data Available**

Harris	2	15
Jefferson	0	1
MRSA Northeast	0	8
Subtotal	2	24
<b>United</b>		
Harris	46	46
Hidalgo	5	1
Jefferson	47	41
MRSA Central	8	12
MRSA Northeast	5	3
Subtotal	111	103
<b>STAR Kids</b>	<b>437</b>	<b>544</b>
<b>STAR+PLUS</b>		
<b>Amerigroup</b>		
Bexar	3	9
El Paso	4	2
Harris	22	39
Jefferson	5	0
Lubbock	0	1
MRSA West	21	8
Tarrant	22	11
Travis	20	2
Subtotal	97	72
<b>Cigna-HealthSpring</b>		
Hidalgo	11	12
MRSA Northeast	22	11
Tarrant	24	8
Subtotal	57	31
<b>Molina</b>		
Bexar	47	73
Dallas	60	48
El Paso	39	19
Harris	53	159
Hidalgo	35	72
Jefferson	50	160
Subtotal	284	531
<b>Superior</b>		
Bexar	80	112
Dallas	107	133
Hidalgo	54	35



**Attachment C3****Primary Care Physicians Terminated SFY21****Blanks = No Data Available**

Lubbock	47	21
MRSA Central	32	35
MRSA West	18	66
Nueces	13	11
Subtotal	351	413
<b>United</b>		
Harris	25	20
Jefferson	25	20
MRSA Central	8	10
MRSA Northeast	7	4
Nueces	0	0
Travis	6	7
Subtotal	71	61
<b>STAR+PLUS</b>	<b>860</b>	<b>1,424</b>
<b>Grand Total</b>	<b>2,985</b>	<b>2,864</b>

**Specialist Terminated SFY21**

**Blanks = No Data Available**

Program/MCO/SDA	Quarter 1	Quarter 2
<b>Medicaid Dental</b>		
DentaQuest	26	34
MCNA	10	10
UnitedHealthCare Dental	11	5
<b>Medicaid Dental</b>	<b>47</b>	<b>49</b>
<b>STAR</b>		
<b>Aetna</b>		
Bexar	50	799
Tarrant	72	809
Subtotal	122	1608
<b>Amerigroup</b>		
Bexar	26	21
Dallas	35	13
Harris	106	53
Jefferson	4	3
Lubbock	11	18
MRSA Central	11	24
MRSA Northeast	104	31
MRSA West	75	54
Tarrant	30	22
Subtotal	402	239
<b>BCBS</b>		
Travis		163
Subtotal		163
<b>CHC</b>		
Harris	153	122
Jefferson	23	4
Subtotal	176	126
<b>Community First</b>		
Bexar	91	563
Subtotal	91	563
<b>Cook Children's</b>		
Tarrant	37	66
Subtotal	37	66
<b>DELL</b>		
Travis	53	20
Subtotal	53	20
<b>Driscoll Children's</b>		
Hidalgo	49	69
Nueces	22	24

**Attachment C3****Specialist Terminated SFY21****Blanks = No Data Available**

Subtotal	71	93
<b>El Paso First</b>		
El Paso	28	29
Subtotal	28	29
<b>FirstCare</b>		
Lubbock	6	1
MRSA West	16	7
Subtotal	22	8
<b>Molina</b>		
Dallas	4	2
El Paso	3	2
Harris	2	13
Hidalgo	3	3
Jefferson	3	12
Subtotal	15	32
<b>Parkland</b>		
Dallas	89	83
Subtotal	89	83
<b>Scott &amp; White</b>		
MRSA Central	49	46
Subtotal	49	46
<b>Superior</b>		
Bexar	209	215
El Paso	68	47
Hidalgo	83	61
Lubbock	86	36
MRSA Central	143	125
MRSA Northeast	208	132
MRSA West	105	211
Nueces	43	46
Travis	252	205
Subtotal	1197	1078
<b>Texas Children's</b>		
Harris	41	101
Jefferson	12	7
Subtotal	53	108
<b>United</b>		
Harris	34	56
Hidalgo	17	15
Jefferson	26	35
Nueces	3	8

**Attachment C3****Specialist Terminated SFY21****Blanks = No Data Available**

Subtotal	80	114
<b>STAR</b>	<b>2,485</b>	<b>4,376</b>
<b>STAR Kids</b>		
<b>Aetna</b>		
Dallas	54	821
Tarrant	79	850
Subtotal	133	1671
<b>Amerigroup</b>		
Dallas	33	13
El Paso	11	5
Harris	105	50
Lubbock	11	18
MRSA West	52	55
Subtotal	212	141
<b>BCBS</b>		
MRSA Central		224
Travis		224
Subtotal		448
<b>Community First</b>		
Bexar	83	372
Subtotal	83	372
<b>Cook Children's</b>		
Tarrant	40	67
Subtotal	40	67
<b>Driscoll Children's</b>		
Hidalgo	56	72
Nueces	24	24
Subtotal	80	96
<b>Superior</b>		
Bexar	189	206
El Paso	67	42
Hidalgo	75	53
Lubbock	78	35
MRSA West	101	204
Nueces	38	42
Travis	213	171
Subtotal	761	753
<b>Texas Children's</b>		
Harris	42	99
Jefferson	12	6

**Attachment C3****Specialist Terminated SFY21****Blanks = No Data Available**

MRSA Northeast	19	34
Subtotal	73	139
<b>United</b>		
Harris	30	54
Hidalgo	19	14
Jefferson	23	33
MRSA Central	9	24
MRSA Northeast	11	12
Subtotal	92	137
<b>STAR Kids</b>	<b>1,474</b>	<b>3,824</b>
<b>STAR+PLUS</b>		
<b>Amerigroup</b>		
Bexar	28	20
El Paso	11	5
Harris	105	55
Jefferson	3	3
Lubbock	11	18
MRSA West	51	53
Tarrant	30	22
Travis	42	19
Subtotal	281	195
<b>Cigna-HealthSpring</b>		
Hidalgo	26	17
MRSA Northeast	58	49
Tarrant	40	51
Subtotal	124	117
<b>Molina</b>		
Bexar	4	4
Dallas	6	3
El Paso	4	4
Harris	5	14
Hidalgo	4	5
Jefferson	3	15
Subtotal	<b>26</b>	<b>45</b>
<b>Superior</b>		
Bexar	217	218
Dallas	297	197
Hidalgo	81	58
Lubbock	86	37
MRSA Central	134	124
MRSA West	105	211

**Specialist Terminated SFY21**

**Blanks = No Data Available**

Nueces	46	47
Subtotal	966	892
<b>United</b>		
Harris	35	56
Jefferson	23	37
MRSA Central	10	26
MRSA Northeast	10	13
Nueces	5	10
Travis	41	33
Subtotal	124	175
<b>STAR+PLUS</b>	<b>1,521</b>	<b>1,424</b>
<b>Grand Total</b>	<b>5,527</b>	<b>9,624</b>

## Attachment D

## Out of Network Utilization SFY21

(Blanks = No Data Available)

Program	MCO	OON ER <20% Standard	OON Inpatient <15% Standard	OON Other Outpatient <20% Standard	OON ER <20% Standard	OON Inpatient <15% Standard	OON Other Outpatient <20% Standard
		2021 Q1	2021 Q1	2021 Q1	2021 Q2	2021 Q2	2021 Q2
STAR	Aetna	7.83%	5.42%	17.79%	7.38%	6.60%	19.30%
	Amerigroup	8.22%	4.18%	6.73%	6.83%	4.13%	4.71%
	BCBS	3.29%	1.05%	14.07%	8.08%	1.08%	12.20%
	CHC	2.55%	0.46%	3.81%	43.51%	16.89%	0.76%
	Community First	2.41%	1.66%	12.39%	2.09%	1.58%	14.03%
	Cook Children's	7.75%	2.41%	12.30%	6.83%	3.26%	13.09%
	DELL	44.63%	19.04%	12.13%	41.19%	17.15%	6.64%
	Driscoll Children's	3.88%	1.91%	8.76%	3.24%	2.19%	8.77%
	El Paso Health	0.92%	0.68%	2.58%	0.56%	0.31%	2.37%
	FirstCare	2.01%	3.12%	14.05%	2.14%	2.60%	14.80%
	Molina	16.38%	14.36%	8.98%	18.11%	13.94%	10.51%
	Parkland	4.30%	1.97%	14.56%	3.64%	1.60%	16.18%
	Scott & White	12.40%	4.49%	8.02%	12.08%	6.17%	8.28%
	Superior	1.35%	1.44%	3.95%	1.79%	1.46%	5.48%
	Texas Children's	18.85%	6.45%	4.68%	18.16%	5.71%	5.16%
	United	8.16%	2.54%	11.55%	4.55%	1.76%	11.94%
STAR Kids	Aetna	10.86%	9.84%	6.83%	13.34%	9.90%	4.87%
	Amerigroup	8.19%	8.13%	4.47%	8.13%	9.18%	3.42%
	BCBS	3.02%	5.57%	10.93%	2.94%	3.15%	15.49%
	Community First	3.23%	3.82%	2.90%	1.62%	1.61%	3.38%
	Cook Children's	9.21%	1.46%	5.08%	10.08%	6.81%	4.69%
	Driscoll Children's	2.47%	12.58%	6.47%	2.52%	8.41%	4.45%
	Superior	2.40%	2.82%	2.99%	3.63%	1.92%	3.83%
	Texas Children's	12.13%	8.62%	2.85%	11.14%	7.97%	3.16%
	United	6.77%	6.91%	4.40%	5.35%	5.89%	4.53%
STAR+PLUS	Amerigroup	5.66%	4.53%	6.34%	5.24%	2.80%	6.54%
	Cigna-HealthSpring	11.06%	10.06%	18.85%	10.27%	11.35%	19.98%
	Molina	18.79%	14.29%	6.47%	19.41%	17.32%	7.41%
	Superior	1.74%	8.73%	7.45%	1.27%	6.79%	8.78%
	United	5.98%	7.25%	11.73%	4.19%	5.18%	5.76%

**Attachment E**  
**Distance Standards SFY21**  
**(Metro, Micro, Rural)**

<b>Provider Type</b>		<b>Distance in Miles</b>		
		<b>Metro</b>	<b>Micro</b>	<b>Rural</b>
<b>Primary Care Provider*</b>	Audiologist	10	20	30
	Behavioral Health - Outpatient	30	60	75
	Cardiovascular Disease	30	30	75
	ENT (Otolaryngology)	20	35	60
	Mental Health Targeted Case Management (TCM) and	30	60	75
	Mental Health Rehabilitative Services (MHR)	30	30	75
	Nursing Facility	75	75	75
	OB/GYN	30	60	75
	Ophthalmologist	20	35	60
	Orthopedist	20	35	60
	Pediatric Sub-Specialists	20	35	60
	Prenatal	10	20	30
	Psychiatrist	30	45	60
	Occupational, Physical, or Speech Therapy	30	60	60
	Urologist	30	45	60
<b>Main Dentist (general or pediatric)</b>		30	30	75
<b>Dental Specialists</b>	Orthodontist	75	75	75
	Pediatric Dental	30	30	75
	Prosthodontist	75	75	75

\*Primary care provider services include acute, chronic, preventive, routine, or urgent care for adults and children

\*\*Specialty care provider services include acute, chronic, preventive, routine, or urgent care for adults and children.



## Attachment H1

## Primary Care Provider Network Access SFY21

(Blanks = No Data Available)

Program County Type MCO	Quarter 1			Quarter 2		
	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)
<b>STAR</b>						
<b>Metro</b>						
Aetna Better Health	76,748	75,765	99%	82,593	81,577	99%
Amerigroup	504,573	499,898	99%	534,681	530,157	99%
Blue Cross and Blue Shield of Texas	31,241	31,130	100%	33,560	33,311	99%
Community First Health Plans	109,084	106,443	98%	115,611	112,626	97%
Community Health Choice	261,022	260,069	100%	275,223	273,878	100%
Cook Children's Health Plan	112,170	110,695	99%	117,811	116,484	99%
Dell Children's Health Plan	24,247	24,081	99%	25,982	25,758	99%
Driscoll Health Plan	135,505	135,168	100%	142,172	141,853	100%
El Paso First	67,556	67,518	100%	71,157	71,113	100%
FirstCare	42,834	42,581	99%	45,191	44,905	99%
Molina Healthcare of Texas	89,048	88,424	99%	93,005	92,244	99%
Parkland	167,303	164,372	98%	176,125	172,602	98%
Right Care from Scott and White Health Plans	33,371	32,000	96%	34,961	33,506	96%
Superior HealthPlan	551,871	541,912	98%	577,239	565,703	98%
Texas Children's Health Plan	366,002	364,671	100%	384,774	383,302	100%
UnitedHealthcare Community Plan	139,264	138,953	100%	149,071	148,677	100%
<b>Subtotal</b>	<b>2,711,839</b>	<b>2,683,680</b>	<b>99%</b>	<b>2,859,156</b>	<b>2,827,696</b>	<b>99%</b>
<b>Micro</b>						
Aetna Better Health	1,241	1,241	100%	1,332	1,328	100%
Amerigroup	33,245	33,227	100%	35,736	35,719	100%
Blue Cross and Blue Shield of Texas	3,927	3,927	100%	4,363	4,363	100%
Community First Health Plans	2,129	2,122	100%	2,270	1,727	76%
Community Health Choice	7,858	7,853	100%	8,621	8,615	100%
Cook Children's Health Plan	3,041	3,041	100%	3,276	3,276	100%
Dell Children's Health Plan	2,333	2,332	100%	2,576	2,576	100%
Driscoll Health Plan	13,321	13,310	100%	14,050	14,037	100%
FirstCare	3,003	2,972	99%	3,152	3,122	99%
Molina Healthcare of Texas	2,799	2,780	99%	2,955	2,935	99%
Right Care from Scott and White Health Plans	3,612	3,612	100%	3,901	3,901	100%
Superior HealthPlan	88,467	88,415	100%	93,457	93,393	100%
Texas Children's Health Plan	11,219	11,202	100%	12,373	12,355	100%
UnitedHealthcare Community Plan	10,450	10,446	100%	11,234	11,229	100%
<b>Subtotal</b>	<b>186,645</b>	<b>186,480</b>	<b>100%</b>	<b>199,296</b>	<b>198,576</b>	<b>100%</b>
<b>Rural</b>						
Aetna Better Health	1,051	1,051	100%	1,163	1,163	100%
Amerigroup	48,183	48,133	100%	51,279	51,226	100%
Blue Cross and Blue Shield of Texas	1,611	1,611	100%	1,713	1,713	100%
Community First Health Plans	5,181	5,181	100%	5,493	5,493	100%
Community Health Choice	8,655	8,655	100%	8,997	8,997	100%
Dell Children's Health Plan	707	706	100%	742	741	100%
Driscoll Health Plan	17,241	17,231	100%	18,014	17,524	97%
El Paso First	15	14	93%	16	15	94%
FirstCare	27,311	27,196	100%	28,619	28,449	99%
Molina Healthcare of Texas	3,191	3,113	98%	3,315	3,238	98%
Parkland	659	659	100%	711	711	100%
Right Care from Scott and White Health Plans	8,413	8,272	98%	8,747	8,596	98%
Superior HealthPlan	111,822	111,210	99%	118,431	117,742	99%
Texas Children's Health Plan	10,004	10,004	100%	10,605	10,605	100%
UnitedHealthcare Community Plan	6,373	6,302	99%	6,825	6,825	100%
<b>Subtotal</b>	<b>250,417</b>	<b>249,338</b>	<b>100%</b>	<b>264,670</b>	<b>263,038</b>	<b>99%</b>
<b>STAR Total</b>	<b>3,148,901</b>	<b>3,119,498</b>	<b>99%</b>	<b>3,323,122</b>	<b>3,289,310</b>	<b>99%</b>
<b>STAR+PLUS</b>						
<b>Metro</b>						
Amerigroup	46,755	46,314	99%	46,683	46,230	99%
Cigna-HealthSpring	11,341	11,019	97%	11,355	11,044	97%

## Attachment H1

## Primary Care Provider Network Access SFY21

(Blanks = No Data Available)

Program County Type MCO	Quarter 1			Quarter 2		
	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)
Molina Healthcare of Texas	29,839	29,366	98%	29,844	29,306	98%
Superior HealthPlan	46,437	45,493	98%	46,281	45,305	98%
UnitedHealthcare Community Plan	41,586	41,298	99%	41,762	41,433	99%
<b>Subtotal</b>	<b>175,958</b>	<b>173,490</b>	<b>99%</b>	<b>175,925</b>	<b>173,318</b>	<b>99%</b>
Micro						
Amerigroup	1,643	1,642	100%	1,629	1,628	100%
Cigna-HealthSpring	3,457	3,454	100%	3,433	3,431	100%
Molina Healthcare of Texas	600	530	88%	605	536	89%
Superior HealthPlan	2,825	2,821	100%	2,821	2,817	100%
UnitedHealthcare Community Plan	6,182	6,180	100%	6,222	6,220	100%
<b>Subtotal</b>	<b>14,707</b>	<b>14,627</b>	<b>99%</b>	<b>14,710</b>	<b>14,632</b>	<b>99%</b>
Rural						
Amerigroup	3,489	3,485	100%	3,493	3,487	100%
Cigna-HealthSpring	1,618	1,603	99%	1,623	1,609	99%
Molina Healthcare of Texas	1,046	1,030	98%	1,024	1,008	98%
Superior HealthPlan	8,167	8,114	99%	8,182	8,122	99%
UnitedHealthcare Community Plan	5,279	5,279	100%	5,330	5,330	100%
<b>Subtotal</b>	<b>19,599</b>	<b>19,511</b>	<b>100%</b>	<b>19,652</b>	<b>19,556</b>	<b>100%</b>
<b>STAR+PLUS Total</b>	<b>210,264</b>	<b>207,628</b>	<b>99%</b>	<b>210,287</b>	<b>207,506</b>	<b>99%</b>
STAR Kids						
Metro						
Aetna Better Health	4,444	4,411	99%	4,646	4,607	99%
Amerigroup	23,606	23,470	99%	24,409	24,281	99%
Blue Cross and Blue Shield of Texas	6,080	5,987	98%	6,213	6,097	98%
Community First Health Plans	6,812	6,666	98%	6,939	6,785	98%
Cook Children's Health Plan	8,979	8,834	98%	9,064	8,855	98%
Driscoll Health Plan	7,906	7,891	100%	8,006	7,993	100%
Superior HealthPlan	22,613	22,366	99%	23,006	22,753	99%
Texas Children's Health Plan	23,313	23,154	99%	23,666	23,504	99%
UnitedHealthcare Community Plan	21,455	21,350	100%	21,673	21,538	99%
<b>Subtotal</b>	<b>125,208</b>	<b>124,129</b>	<b>99%</b>	<b>127,622</b>	<b>126,413</b>	<b>99%</b>
Micro						
Aetna Better Health	41	41	100%	43	43	100%
Amerigroup	270	270	100%	275	275	100%
Blue Cross and Blue Shield of Texas	620	620	100%	628	628	100%
Community First Health Plans	102	68	67%	107	67	63%
Cook Children's Health Plan	123	123	100%	121	121	100%
Driscoll Health Plan	488	488	100%	494	494	100%
Superior HealthPlan	1,461	1,461	100%	1,488	1,488	100%
Texas Children's Health Plan	2,201	2,200	100%	2,325	2,324	100%
UnitedHealthcare Community Plan	2,813	2,810	100%	2,876	2,873	100%
<b>Subtotal</b>	<b>8,119</b>	<b>8,081</b>	<b>100%</b>	<b>8,357</b>	<b>8,313</b>	<b>99%</b>
Rural						
Amerigroup	1,816	1,812	100%	1,849	1,845	100%
Blue Cross and Blue Shield of Texas	857	857	100%	879	874	99%
Community First Health Plans	245	244	100%	241	240	100%
Driscoll Health Plan	779	779	100%	786	756	96%
Superior HealthPlan	2,301	2,273	99%	2,356	2,333	99%
Texas Children's Health Plan	1,299	1,293	100%	1,349	1,343	100%
UnitedHealthcare Community Plan	2,349	2,349	100%	2,401	2,401	100%
<b>Subtotal</b>	<b>9,646</b>	<b>9,607</b>	<b>100%</b>	<b>9,861</b>	<b>9,792</b>	<b>99%</b>
<b>STAR Kids Total</b>	<b>142,973</b>	<b>141,817</b>	<b>99%</b>	<b>145,840</b>	<b>144,518</b>	<b>99%</b>
<b>Grand Total</b>	<b>3,502,138</b>	<b>3,468,943</b>	<b>99%</b>	<b>3,679,249</b>	<b>3,641,334</b>	<b>99%</b>

## Attachment H2

Specialist Network Access Analysis SFY21  
(Blanks = No Data Available)

Program County Type MCO	Quarter 1			Quarter 2		
	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)
<b>Audiologist</b>						
<b>STAR</b>						
Metro	2,711,839	2,031,153	75%	2,859,156	2,303,744	81%
Aetna Better Health	76,748	75,007	98%	82,593	80,691	98%
Amerigroup	504,573	434,106	86%	534,681	471,230	88%
Blue Cross and Blue Shield of Texas	31,241	31,216	100%	33,560	33,529	100%
Community First Health Plans	109,084	109,084	100%	115,611	115,611	100%
Community Health Choice	261,022	238,780	91%	275,223	246,826	90%
Cook Children's Health Plan	112,170	0	0%	117,811	115,129	98%
Dell Children's Health Plan	24,247	24,220	100%	25,982	25,948	100%
Driscoll Health Plan	135,505	107,579	79%	142,172	112,921	79%
El Paso First	67,556	67,555	100%	71,157	71,154	100%
FirstCare	42,834	0	0%	45,191	0	0%
Molina Healthcare of Texas	89,048	72,041	81%	93,005	64,509	69%
Parkland	167,303	155,985	93%	176,125	164,455	93%
Right Care from Scott and White Health Plans	33,371	20,392	61%	34,961	21,372	61%
Superior HealthPlan	551,871	292,043	53%	577,239	322,036	56%
Texas Children's Health Plan	366,002	333,062	91%	384,774	349,686	91%
UnitedHealthcare Community Plan	139,264	70,083	50%	149,071	108,647	73%
Micro	186,645	97,018	52%	199,296	123,611	62%
Aetna Better Health	1,241	1,241	100%	1,332	1,332	100%
Amerigroup	33,245	12,122	36%	35,736	26,605	74%
Blue Cross and Blue Shield of Texas	3,927	3,927	100%	4,363	4,363	100%
Community First Health Plans	2,129	2,129	100%	2,270	2,270	100%
Community Health Choice	7,858	5,930	75%	8,621	6,623	77%
Cook Children's Health Plan	3,041	0	0%	3,276	3,276	100%
Dell Children's Health Plan	2,333	2,333	100%	2,576	2,576	100%
Driscoll Health Plan	13,321	10,864	82%	14,050	11,496	82%
FirstCare	3,003	0	0%	3,152	0	0%
Molina Healthcare of Texas	2,799	1,613	58%	2,955	1,708	58%
Right Care from Scott and White Health Plans	3,612	2,615	72%	3,901	2,828	72%
Superior HealthPlan	88,467	41,900	47%	93,457	44,330	47%
Texas Children's Health Plan	11,219	8,985	80%	12,373	10,006	81%
UnitedHealthcare Community Plan	10,450	3,359	32%	11,234	6,198	55%
Rural	250,417	162,860	65%	264,670	166,832	63%
Aetna Better Health	1,051	1,051	100%	1,163	1,163	100%
Amerigroup	48,183	29,325	61%	51,279	35,850	70%
Blue Cross and Blue Shield of Texas	1,611	1,611	100%	1,713	1,713	100%
Community First Health Plans	5,181	5,181	100%	5,493	5,493	100%
Community Health Choice	8,655	7,342	85%	8,997	7,624	85%
Dell Children's Health Plan	707	707	100%	742	742	100%
Driscoll Health Plan	17,241	15,011	87%	18,014	15,543	86%
El Paso First	15	15	100%	16	16	100%
FirstCare	27,311	0	0%	28,619	0	0%
Molina Healthcare of Texas	3,191	1,970	62%	3,315	1,669	50%
Parkland	659	659	100%	711	711	100%
Right Care from Scott and White Health Plans	8,413	5,631	67%	8,747	5,830	67%
Superior HealthPlan	111,822	84,160	75%	118,431	79,061	67%
Texas Children's Health Plan	10,004	7,007	70%	10,605	7,385	70%
UnitedHealthcare Community Plan	6,373	3,190	50%	6,825	4,032	59%
<b>STAR Total</b>	<b>3,148,901</b>	<b>2,291,031</b>	<b>73%</b>	<b>3,323,122</b>	<b>2,594,187</b>	<b>78%</b>
<b>STAR+PLUS</b>						
Metro	175,958	135,299	77%	175,925	132,153	75%
Amerigroup	46,755	37,966	81%	46,683	38,006	81%
Cigna-HealthSpring	11,341	5,893	52%	11,355	6,140	54%
Molina Healthcare of Texas	29,839	23,746	80%	29,844	23,093	77%
Superior HealthPlan	46,437	34,605	75%	46,281	31,960	69%
UnitedHealthcare Community Plan	41,586	33,089	80%	41,762	32,954	79%
Micro	14,707	8,413	57%	14,710	9,647	66%
Amerigroup	1,643	1,292	79%	1,629	1,284	79%
Cigna-HealthSpring	3,457	599	17%	3,433	1,789	52%
Molina Healthcare of Texas	600	334	56%	605	342	57%
Superior HealthPlan	2,825	2,192	78%	2,821	2,195	78%
UnitedHealthcare Community Plan	6,182	3,996	65%	6,222	4,037	65%
Rural	19,599	13,885	71%	19,652	13,470	69%

## Attachment H2

Specialist Network Access Analysis SFY21  
(Blanks = No Data Available)

Program County Type MCO	Quarter 1			Quarter 2		
	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)
Amerigroup	3,489	1,997	57%	3,493	2,007	57%
Cigna-HealthSpring	1,618	1,048	65%	1,623	1,115	69%
Molina Healthcare of Texas	1,046	810	77%	1,024	768	75%
Superior HealthPlan	8,167	6,436	79%	8,182	5,889	72%
UnitedHealthcare Community Plan	5,279	3,594	68%	5,330	3,691	69%
<b>STAR+PLUS Total</b>	<b>210,264</b>	<b>157,597</b>	<b>75%</b>	<b>210,287</b>	<b>155,270</b>	<b>74%</b>
<b>STAR Kids</b>						
Metro	125,208	89,844	72%	127,622	100,448	79%
Aetna Better Health	4,444	4,335	98%	4,646	4,539	98%
Amerigroup	23,606	19,863	84%	24,409	20,639	85%
Blue Cross and Blue Shield of Texas	6,080	5,478	90%	6,213	5,606	90%
Community First Health Plans	6,812	6,812	100%	6,939	6,939	100%
Cook Children's Health Plan	8,979	0	0%	9,064	8,933	99%
Driscoll Health Plan	7,906	6,355	80%	8,006	6,409	80%
Superior HealthPlan	22,613	14,015	62%	23,006	13,952	61%
Texas Children's Health Plan	23,313	18,759	80%	23,666	19,030	80%
UnitedHealthcare Community Plan	21,455	14,227	66%	21,673	14,401	66%
Micro	8,119	4,606	57%	8,357	4,845	58%
Aetna Better Health	41	41	100%	43	43	100%
Amerigroup	270	270	100%	275	275	100%
Blue Cross and Blue Shield of Texas	620	620	100%	628	628	100%
Community First Health Plans	102	102	100%	107	107	100%
Cook Children's Health Plan	123	0	0%	121	121	100%
Driscoll Health Plan	488	433	89%	494	439	89%
Superior HealthPlan	1,461	956	65%	1,488	972	65%
Texas Children's Health Plan	2,201	566	26%	2,325	608	26%
UnitedHealthcare Community Plan	2,813	1,618	58%	2,876	1,652	57%
Rural	9,646	6,664	69%	9,861	6,673	68%
Amerigroup	1,816	1,060	58%	1,849	1,075	58%
Blue Cross and Blue Shield of Texas	857	769	90%	879	786	89%
Community First Health Plans	245	245	100%	241	241	100%
Driscoll Health Plan	779	692	89%	786	689	88%
Superior HealthPlan	2,301	1,656	72%	2,356	1,427	61%
Texas Children's Health Plan	1,299	762	59%	1,349	799	59%
UnitedHealthcare Community Plan	2,349	1,480	63%	2,401	1,656	69%
<b>STAR Kids Total</b>	<b>142,973</b>	<b>101,114</b>	<b>71%</b>	<b>145,840</b>	<b>111,966</b>	<b>77%</b>
<b>Audiologist Total</b>	<b>3,502,138</b>	<b>2,549,742</b>	<b>73%</b>	<b>3,679,249</b>	<b>2,861,423</b>	<b>78%</b>
<b>Behavioral Health - Outpatient</b>						
<b>STAR</b>						
Metro	2,711,839	2,694,483	99%	2,859,156	2,840,536	99%
Aetna Better Health	76,748	76,748	100%	82,593	82,593	100%
Amerigroup	504,573	504,564	100%	534,681	534,599	100%
Blue Cross and Blue Shield of Texas	31,241	31,241	100%	33,560	33,560	100%
Community First Health Plans	109,084	109,084	100%	115,611	115,611	100%
Community Health Choice	261,022	261,022	100%	275,223	275,223	100%
Cook Children's Health Plan	112,170	112,110	100%	117,811	117,811	100%
Dell Children's Health Plan	24,247	24,247	100%	25,982	25,982	100%
Driscoll Health Plan	135,505	135,505	100%	142,172	142,169	100%
El Paso First	67,556	67,556	100%	71,157	71,157	100%
FirstCare	42,834	25,779	60%	45,191	26,894	60%
Molina Healthcare of Texas	89,048	89,048	100%	93,005	93,005	100%
Parkland	167,303	167,303	100%	176,125	176,125	100%
Right Care from Scott and White Health Plans	33,371	33,371	100%	34,961	34,961	100%
Superior HealthPlan	551,871	551,639	100%	577,239	577,001	100%
Texas Children's Health Plan	366,002	366,002	100%	384,774	384,774	100%
UnitedHealthcare Community Plan	139,264	139,264	100%	149,071	149,071	100%
Micro	186,645	183,643	98%	199,296	196,321	99%
Aetna Better Health	1,241	1,172	94%	1,332	1,245	93%
Amerigroup	33,245	32,329	97%	35,736	34,616	97%
Blue Cross and Blue Shield of Texas	3,927	3,927	100%	4,363	4,363	100%
Community First Health Plans	2,129	2,129	100%	2,270	2,270	100%
Community Health Choice	7,858	7,858	100%	8,621	8,621	100%
Cook Children's Health Plan	3,041	1,904	63%	3,276	2,439	74%
Dell Children's Health Plan	2,333	2,333	100%	2,576	2,576	100%

## Attachment H2

Specialist Network Access Analysis SFY21  
(Blanks = No Data Available)

Program County Type MCO	Quarter 1			Quarter 2		
	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)
Driscoll Health Plan	13,321	13,321	100%	14,050	14,050	100%
FirstCare	3,003	2,972	99%	3,152	3,122	99%
Molina Healthcare of Texas	2,799	2,799	100%	2,955	2,955	100%
Right Care from Scott and White Health Plans	3,612	2,763	76%	3,901	3,000	77%
Superior HealthPlan	88,467	88,467	100%	93,457	93,457	100%
Texas Children's Health Plan	11,219	11,219	100%	12,373	12,373	100%
UnitedHealthcare Community Plan	10,450	10,450	100%	11,234	11,234	100%
Rural	250,417	239,387	96%	264,670	255,656	97%
Aetna Better Health	1,051	1,051	100%	1,163	1,163	100%
Amerigroup	48,183	47,965	100%	51,279	51,044	100%
Blue Cross and Blue Shield of Texas	1,611	1,611	100%	1,713	1,713	100%
Community First Health Plans	5,181	5,181	100%	5,493	5,493	100%
Community Health Choice	8,655	8,655	100%	8,997	8,997	100%
Dell Children's Health Plan	707	707	100%	742	742	100%
Driscoll Health Plan	17,241	17,241	100%	18,014	18,014	100%
El Paso First	15	15	100%	16	16	100%
FirstCare	27,311	16,803	62%	28,619	20,165	70%
Molina Healthcare of Texas	3,191	3,191	100%	3,315	3,315	100%
Parkland	659	659	100%	711	711	100%
Right Care from Scott and White Health Plans	8,413	8,413	100%	8,747	8,747	100%
Superior HealthPlan	111,822	111,518	100%	118,431	118,106	100%
Texas Children's Health Plan	10,004	10,004	100%	10,605	10,605	100%
UnitedHealthcare Community Plan	6,373	6,373	100%	6,825	6,825	100%
<b>STAR Total</b>	<b>3,148,901</b>	<b>3,117,513</b>	<b>99%</b>	<b>3,323,122</b>	<b>3,292,513</b>	<b>99%</b>
<b>STAR+PLUS</b>						
Metro	175,958	175,954	100%	175,925	175,921	100%
Amerigroup	46,755	46,755	100%	46,683	46,683	100%
Cigna-HealthSpring	11,341	11,338	100%	11,355	11,352	100%
Molina Healthcare of Texas	29,839	29,838	100%	29,844	29,843	100%
Superior HealthPlan	46,437	46,437	100%	46,281	46,281	100%
UnitedHealthcare Community Plan	41,586	41,586	100%	41,762	41,762	100%
Micro	14,707	14,707	100%	14,710	14,710	100%
Amerigroup	1,643	1,643	100%	1,629	1,629	100%
Cigna-HealthSpring	3,457	3,457	100%	3,433	3,433	100%
Molina Healthcare of Texas	600	600	100%	605	605	100%
Superior HealthPlan	2,825	2,825	100%	2,821	2,821	100%
UnitedHealthcare Community Plan	6,182	6,182	100%	6,222	6,222	100%
Rural	19,599	19,563	100%	19,652	19,613	100%
Amerigroup	3,489	3,480	100%	3,493	3,483	100%
Cigna-HealthSpring	1,618	1,618	100%	1,623	1,623	100%
Molina Healthcare of Texas	1,046	1,046	100%	1,024	1,024	100%
Superior HealthPlan	8,167	8,140	100%	8,182	8,153	100%
UnitedHealthcare Community Plan	5,279	5,279	100%	5,330	5,330	100%
<b>STAR+PLUS Total</b>	<b>210,264</b>	<b>210,224</b>	<b>100%</b>	<b>210,287</b>	<b>210,244</b>	<b>100%</b>
<b>STAR Kids</b>						
Metro	125,208	125,203	100%	127,622	127,618	100%
Aetna Better Health	4,444	4,444	100%	4,646	4,646	100%
Amerigroup	23,606	23,606	100%	24,409	24,409	100%
Blue Cross and Blue Shield of Texas	6,080	6,080	100%	6,213	6,213	100%
Community First Health Plans	6,812	6,812	100%	6,939	6,939	100%
Cook Children's Health Plan	8,979	8,978	100%	9,064	9,064	100%
Driscoll Health Plan	7,906	7,906	100%	8,006	8,006	100%
Superior HealthPlan	22,613	22,613	100%	23,006	23,006	100%
Texas Children's Health Plan	23,313	23,309	100%	23,666	23,662	100%
UnitedHealthcare Community Plan	21,455	21,455	100%	21,673	21,673	100%
Micro	8,119	8,035	99%	8,357	8,331	100%
Aetna Better Health	41	41	100%	43	43	100%
Amerigroup	270	270	100%	275	275	100%
Blue Cross and Blue Shield of Texas	620	578	93%	628	628	100%
Community First Health Plans	102	102	100%	107	107	100%
Cook Children's Health Plan	123	83	67%	121	95	79%
Driscoll Health Plan	488	488	100%	494	494	100%

## Attachment H2

Specialist Network Access Analysis SFY21  
(Blanks = No Data Available)

Program County Type MCO	Quarter 1			Quarter 2		
	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)
Superior HealthPlan	1,461	1,461	100%	1,488	1,488	100%
Texas Children's Health Plan	2,201	2,199	100%	2,325	2,325	100%
UnitedHealthcare Community Plan	2,813	2,813	100%	2,876	2,876	100%
Rural	9,646	9,642	100%	9,861	9,856	100%
Amerigroup	1,816	1,816	100%	1,849	1,848	100%
Blue Cross and Blue Shield of Texas	857	857	100%	879	879	100%
Community First Health Plans	245	245	100%	241	241	100%
Driscoll Health Plan	779	779	100%	786	786	100%
Superior HealthPlan	2,301	2,297	100%	2,356	2,352	100%
Texas Children's Health Plan	1,299	1,299	100%	1,349	1,349	100%
UnitedHealthcare Community Plan	2,349	2,349	100%	2,401	2,401	100%
<b>STAR Kids Total</b>	<b>142,973</b>	<b>142,880</b>	<b>100%</b>	<b>145,840</b>	<b>145,805</b>	<b>100%</b>
<b>BH - Outpatient Total</b>	<b>3,502,138</b>	<b>3,470,617</b>	<b>99%</b>	<b>3,679,249</b>	<b>3,648,562</b>	<b>99%</b>
<b>Cardiovascular Disease</b>						
<b>STAR</b>						
Metro	2,711,839	2,564,158	95%	2,859,156	2,705,511	95%
Aetna Better Health	76,748	75,164	98%	82,593	80,836	98%
Amerigroup	504,573	495,950	98%	534,681	522,782	98%
Blue Cross and Blue Shield of Texas	31,241	30,152	97%	33,560	33,355	99%
Community First Health Plans	109,084	108,721	100%	115,611	115,214	100%
Community Health Choice	261,022	260,914	100%	275,223	275,107	100%
Cook Children's Health Plan	112,170	92,997	83%	117,811	111,940	95%
Dell Children's Health Plan	24,247	21,604	89%	25,982	23,004	89%
Driscoll Health Plan	135,505	114,904	85%	142,172	120,644	85%
El Paso First	67,556	67,526	100%	71,157	71,142	100%
FirstCare	42,834	11,185	26%	45,191	11,802	26%
Molina Healthcare of Texas	89,048	88,311	99%	93,005	81,641	88%
Parkland	167,303	154,055	92%	176,125	162,176	92%
Right Care from Scott and White Health Plans	33,371	17,452	52%	34,961	18,289	52%
Superior HealthPlan	551,871	529,419	96%	577,239	553,939	96%
Texas Children's Health Plan	366,002	365,543	100%	384,774	384,042	100%
UnitedHealthcare Community Plan	139,264	130,261	94%	149,071	139,598	94%
Micro	186,645	147,037	79%	199,296	158,537	80%
Aetna Better Health	1,241	1,191	96%	1,332	1,231	92%
Amerigroup	33,245	31,387	94%	35,736	33,501	94%
Blue Cross and Blue Shield of Texas	3,927	3,785	96%	4,363	4,363	100%
Community First Health Plans	2,129	2,129	100%	2,270	2,270	100%
Community Health Choice	7,858	7,805	99%	8,621	8,575	99%
Cook Children's Health Plan	3,041	1,332	44%	3,276	2,417	74%
Dell Children's Health Plan	2,333	2,104	90%	2,576	2,330	90%
Driscoll Health Plan	13,321	10,870	82%	14,050	11,502	82%
FirstCare	3,003	0	0%	3,152	0	0%
Molina Healthcare of Texas	2,799	914	33%	2,955	1,354	46%
Right Care from Scott and White Health Plans	3,612	3,219	89%	3,901	3,456	89%
Superior HealthPlan	88,467	63,947	72%	93,457	67,615	72%
Texas Children's Health Plan	11,219	11,093	99%	12,373	11,996	97%
UnitedHealthcare Community Plan	10,450	7,261	69%	11,234	7,927	71%
Rural	250,417	209,042	83%	264,670	222,009	84%
Aetna Better Health	1,051	1,051	100%	1,163	1,163	100%
Amerigroup	48,183	44,127	92%	51,279	47,797	93%
Blue Cross and Blue Shield of Texas	1,611	1,611	100%	1,713	1,713	100%
Community First Health Plans	5,181	5,181	100%	5,493	5,493	100%
Community Health Choice	8,655	8,623	100%	8,997	8,966	100%
Dell Children's Health Plan	707	649	92%	742	683	92%
Driscoll Health Plan	17,241	17,241	100%	18,014	18,014	100%
El Paso First	15	14	93%	16	15	94%
FirstCare	27,311	3,806	14%	28,619	3,964	14%
Molina Healthcare of Texas	3,191	3,152	99%	3,315	3,206	97%
Parkland	659	656	100%	711	706	99%
Right Care from Scott and White Health Plans	8,413	6,266	74%	8,747	7,112	81%
Superior HealthPlan	111,822	100,604	90%	118,431	106,071	90%
Texas Children's Health Plan	10,004	9,936	99%	10,605	10,531	99%

## Attachment H2

Specialist Network Access Analysis SFY21  
(Blanks = No Data Available)

Program County Type MCO	Quarter 1			Quarter 2		
	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)
UnitedHealthcare Community Plan	6,373	6,125	96%	6,825	6,575	96%
<b>STAR Total</b>	<b>3,148,901</b>	<b>2,920,237</b>	<b>93%</b>	<b>3,323,122</b>	<b>3,086,057</b>	<b>93%</b>
<b>STAR+PLUS</b>						
Metro	175,958	171,620	98%	175,925	170,957	97%
Amerigroup	46,755	46,448	99%	46,683	46,383	99%
Cigna-HealthSpring	11,341	10,684	94%	11,355	10,697	94%
Molina Healthcare of Texas	29,839	29,468	99%	29,844	28,849	97%
Superior HealthPlan	46,437	44,203	95%	46,281	44,061	95%
UnitedHealthcare Community Plan	41,586	40,817	98%	41,762	40,967	98%
Micro	14,707	13,022	89%	14,710	12,892	88%
Amerigroup	1,643	1,500	91%	1,629	1,629	100%
Cigna-HealthSpring	3,457	2,826	82%	3,433	2,486	72%
Molina Healthcare of Texas	600	408	68%	605	457	76%
Superior HealthPlan	2,825	2,274	80%	2,821	2,274	81%
UnitedHealthcare Community Plan	6,182	6,014	97%	6,222	6,046	97%
Rural	19,599	18,074	92%	19,652	18,222	93%
Amerigroup	3,489	3,029	87%	3,493	3,170	91%
Cigna-HealthSpring	1,618	1,600	99%	1,623	1,605	99%
Molina Healthcare of Texas	1,046	1,037	99%	1,024	1,005	98%
Superior HealthPlan	8,167	7,307	89%	8,182	7,303	89%
UnitedHealthcare Community Plan	5,279	5,101	97%	5,330	5,139	96%
<b>STAR+PLUS Total</b>	<b>210,264</b>	<b>202,716</b>	<b>96%</b>	<b>210,287</b>	<b>202,071</b>	<b>96%</b>
<b>STAR Kids</b>						
Metro	125,208	117,098	94%	127,622	120,228	94%
Aetna Better Health	4,444	4,331	97%	4,646	4,534	98%
Amerigroup	23,606	23,409	99%	24,409	23,852	98%
Blue Cross and Blue Shield of Texas	6,080	4,488	74%	6,213	4,599	74%
Community First Health Plans	6,812	6,796	100%	6,939	6,920	100%
Cook Children's Health Plan	8,979	7,273	81%	9,064	8,554	94%
Driscoll Health Plan	7,906	6,755	85%	8,006	6,826	85%
Superior HealthPlan	22,613	20,431	90%	23,006	20,789	90%
Texas Children's Health Plan	23,313	23,235	100%	23,666	23,571	100%
UnitedHealthcare Community Plan	21,455	20,380	95%	21,673	20,583	95%
Micro	8,119	6,998	86%	8,357	7,226	86%
Aetna Better Health	41	38	93%	43	38	88%
Amerigroup	270	270	100%	275	275	100%
Blue Cross and Blue Shield of Texas	620	546	88%	628	557	89%
Community First Health Plans	102	102	100%	107	107	100%
Cook Children's Health Plan	123	64	52%	121	92	76%
Driscoll Health Plan	488	433	89%	494	439	89%
Superior HealthPlan	1,461	991	68%	1,488	1,006	68%
Texas Children's Health Plan	2,201	2,024	92%	2,325	2,115	91%
UnitedHealthcare Community Plan	2,813	2,530	90%	2,876	2,597	90%
Rural	9,646	8,594	89%	9,861	8,830	90%
Amerigroup	1,816	1,613	89%	1,849	1,642	89%
Blue Cross and Blue Shield of Texas	857	804	94%	879	875	100%
Community First Health Plans	245	245	100%	241	241	100%
Driscoll Health Plan	779	779	100%	786	786	100%
Superior HealthPlan	2,301	1,725	75%	2,356	1,753	74%
Texas Children's Health Plan	1,299	1,289	99%	1,349	1,339	99%
UnitedHealthcare Community Plan	2,349	2,139	91%	2,401	2,194	91%
<b>STAR Kids Total</b>	<b>142,973</b>	<b>132,690</b>	<b>93%</b>	<b>145,840</b>	<b>136,284</b>	<b>93%</b>
<b>Cardiovascular Disease Total</b>	<b>3,502,138</b>	<b>3,255,643</b>	<b>93%</b>	<b>3,679,249</b>	<b>3,424,412</b>	<b>93%</b>
<b>ENT (Otolaryngology)</b>						
<b>STAR</b>						
Metro	2,711,839	2,536,214	94%	2,859,156	2,709,316	95%
Aetna Better Health	76,748	76,645	100%	82,593	82,479	100%
Amerigroup	504,573	494,407	98%	534,681	527,437	99%
Blue Cross and Blue Shield of Texas	31,241	30,660	98%	33,560	32,905	98%
Community First Health Plans	109,084	109,084	100%	115,611	115,611	100%
Community Health Choice	261,022	256,593	98%	275,223	270,398	98%
Cook Children's Health Plan	112,170	73,880	66%	117,811	111,416	95%



## Attachment H2

Specialist Network Access Analysis SFY21  
(Blanks = No Data Available)

Program County Type MCO	Quarter 1			Quarter 2		
	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)
Dell Children's Health Plan	24,247	24,222	100%	25,982	25,952	100%
Driscoll Health Plan	135,505	135,467	100%	142,172	142,135	100%
El Paso First	67,556	67,555	100%	71,157	71,154	100%
FirstCare	42,834	0	0%	45,191	0	0%
Molina Healthcare of Texas	89,048	86,369	97%	93,005	90,151	97%
Parkland	167,303	163,830	98%	176,125	172,421	98%
Right Care from Scott and White Health Plans	33,371	20,392	61%	34,961	21,372	61%
Superior HealthPlan	551,871	500,488	91%	577,239	523,248	91%
Texas Children's Health Plan	366,002	366,002	100%	384,774	382,424	99%
UnitedHealthcare Community Plan	139,264	130,620	94%	149,071	140,213	94%
Micro	186,645	171,807	92%	199,296	183,851	92%
Aetna Better Health	1,241	1,241	100%	1,332	1,332	100%
Amerigroup	33,245	33,245	100%	35,736	35,736	100%
Blue Cross and Blue Shield of Texas	3,927	3,927	100%	4,363	4,363	100%
Community First Health Plans	2,129	2,129	100%	2,270	2,270	100%
Community Health Choice	7,858	7,858	100%	8,621	8,621	100%
Cook Children's Health Plan	3,041	2,935	97%	3,276	3,276	100%
Dell Children's Health Plan	2,333	2,333	100%	2,576	2,576	100%
Driscoll Health Plan	13,321	10,870	82%	14,050	11,502	82%
FirstCare	3,003	0	0%	3,152	0	0%
Molina Healthcare of Texas	2,799	1,694	61%	2,955	1,806	61%
Right Care from Scott and White Health Plans	3,612	2,615	72%	3,901	2,828	72%
Superior HealthPlan	88,467	82,424	93%	93,457	87,128	93%
Texas Children's Health Plan	11,219	11,219	100%	12,373	12,373	100%
UnitedHealthcare Community Plan	10,450	9,317	89%	11,234	10,040	89%
Rural	250,417	203,416	81%	264,670	214,409	81%
Aetna Better Health	1,051	1,051	100%	1,163	1,163	100%
Amerigroup	48,183	44,511	92%	51,279	48,045	94%
Blue Cross and Blue Shield of Texas	1,611	1,611	100%	1,713	1,713	100%
Community First Health Plans	5,181	5,181	100%	5,493	5,493	100%
Community Health Choice	8,655	8,655	100%	8,997	8,997	100%
Dell Children's Health Plan	707	707	100%	742	742	100%
Driscoll Health Plan	17,241	17,231	100%	18,014	18,014	100%
El Paso First	15	15	100%	16	16	100%
FirstCare	27,311	0	0%	28,619	0	0%
Molina Healthcare of Texas	3,191	3,144	99%	3,315	3,261	98%
Parkland	659	659	100%	711	711	100%
Right Care from Scott and White Health Plans	8,413	6,520	77%	8,747	5,888	67%
Superior HealthPlan	111,822	98,385	88%	118,431	103,595	87%
Texas Children's Health Plan	10,004	10,004	100%	10,605	10,605	100%
UnitedHealthcare Community Plan	6,373	5,742	90%	6,825	6,166	90%
<b>STAR Total</b>	<b>3,148,901</b>	<b>2,911,437</b>	<b>92%</b>	<b>3,323,122</b>	<b>3,107,576</b>	<b>94%</b>
<b>STAR+PLUS</b>						
Metro	175,958	169,227	96%	175,925	169,356	96%
Amerigroup	46,755	46,670	100%	46,683	46,514	100%
Cigna-HealthSpring	11,341	9,976	88%	11,355	10,150	89%
Molina Healthcare of Texas	29,839	28,345	95%	29,844	28,344	95%
Superior HealthPlan	46,437	43,110	93%	46,281	42,973	93%
UnitedHealthcare Community Plan	41,586	41,126	99%	41,762	41,375	99%
Micro	14,707	14,120	96%	14,710	14,137	96%
Amerigroup	1,643	1,643	100%	1,629	1,629	100%
Cigna-HealthSpring	3,457	3,346	97%	3,433	3,328	97%
Molina Healthcare of Texas	600	412	69%	605	421	70%
Superior HealthPlan	2,825	2,537	90%	2,821	2,537	90%
UnitedHealthcare Community Plan	6,182	6,182	100%	6,222	6,222	100%
Rural	19,599	17,951	92%	19,652	18,005	92%
Amerigroup	3,489	3,171	91%	3,493	3,186	91%
Cigna-HealthSpring	1,618	1,593	98%	1,623	1,617	100%
Molina Healthcare of Texas	1,046	1,018	97%	1,024	996	97%
Superior HealthPlan	8,167	7,220	88%	8,182	7,206	88%
UnitedHealthcare Community Plan	5,279	4,949	94%	5,330	5,000	94%
<b>STAR+PLUS Total</b>	<b>210,264</b>	<b>201,298</b>	<b>96%</b>	<b>210,287</b>	<b>201,498</b>	<b>96%</b>



## Attachment H2

Specialist Network Access Analysis SFY21  
(Blanks = No Data Available)

Program County Type MCO	Quarter 1			Quarter 2		
	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)
<b>STAR Kids</b>						
Metro	125,208	116,989	93%	127,622	122,585	96%
Aetna Better Health	4,444	4,429	100%	4,646	4,632	100%
Amerigroup	23,606	23,567	100%	24,409	24,310	100%
Blue Cross and Blue Shield of Texas	6,080	6,075	100%	6,213	6,208	100%
Community First Health Plans	6,812	6,812	100%	6,939	6,939	100%
Cook Children's Health Plan	8,979	4,447	50%	9,064	8,254	91%
Driscoll Health Plan	7,906	7,904	100%	8,006	8,004	100%
Superior HealthPlan	22,613	19,966	88%	23,006	20,316	88%
Texas Children's Health Plan	23,313	23,294	100%	23,666	23,240	98%
UnitedHealthcare Community Plan	21,455	20,495	96%	21,673	20,682	95%
Micro	8,119	7,729	95%	8,357	7,966	95%
Aetna Better Health	41	41	100%	43	43	100%
Amerigroup	270	270	100%	275	275	100%
Blue Cross and Blue Shield of Texas	620	620	100%	628	628	100%
Community First Health Plans	102	102	100%	107	107	100%
Cook Children's Health Plan	123	120	98%	121	121	100%
Driscoll Health Plan	488	433	89%	494	439	89%
Superior HealthPlan	1,461	1,174	80%	1,488	1,197	80%
Texas Children's Health Plan	2,201	2,201	100%	2,325	2,325	100%
UnitedHealthcare Community Plan	2,813	2,768	98%	2,876	2,831	98%
Rural	9,646	8,481	88%	9,861	8,698	88%
Amerigroup	1,816	1,587	87%	1,849	1,614	87%
Blue Cross and Blue Shield of Texas	857	782	91%	879	822	94%
Community First Health Plans	245	245	100%	241	241	100%
Driscoll Health Plan	779	779	100%	786	786	100%
Superior HealthPlan	2,301	1,774	77%	2,356	1,820	77%
Texas Children's Health Plan	1,299	1,299	100%	1,349	1,349	100%
UnitedHealthcare Community Plan	2,349	2,015	86%	2,401	2,066	86%
<b>STAR Kids Total</b>	<b>142,973</b>	<b>133,199</b>	<b>93%</b>	<b>145,840</b>	<b>139,249</b>	<b>95%</b>
<b>ENT Total</b>	<b>3,502,138</b>	<b>3,245,934</b>	<b>93%</b>	<b>3,679,249</b>	<b>3,448,323</b>	<b>94%</b>
<b>Mental Health Targeted Case Management (TCM) and Mental Health Rehabilitative Services (MHR)</b>						
<b>STAR</b>						
Metro	2,711,839	1,959,790	72%	2,859,156	1,982,901	69%
Aetna Better Health	76,748	31,289	41%	82,593	78,230	95%
Amerigroup	504,573	379,691	75%	534,681	294,918	55%
Blue Cross and Blue Shield of Texas	31,241	31,144	100%	33,560	33,453	100%
Community First Health Plans	109,084	80,839	74%	115,611	85,467	74%
Community Health Choice	261,022	252,569	97%	275,223	266,469	97%
Cook Children's Health Plan	112,170	0	0%	117,811	0	0%
Dell Children's Health Plan	24,247	24,153	100%	25,982	23,323	90%
Driscoll Health Plan	135,505	25,469	19%	142,172	34,308	24%
El Paso First	67,556	67,556	100%	71,157	71,157	100%
FirstCare	42,834	0	0%	45,191	0	0%
Molina Healthcare of Texas	89,048	45,159	51%	93,005	48,038	52%
Parkland	167,303	162,354	97%	176,125	169,495	96%
Right Care from Scott and White Health Plans	33,371	0	0%	34,961	0	0%
Superior HealthPlan	551,871	418,092	76%	577,239	437,396	76%
Texas Children's Health Plan	366,002	321,470	88%	384,774	355,568	92%
UnitedHealthcare Community Plan	139,264	120,005	86%	149,071	85,079	57%
Micro	186,645	60,157	32%	199,296	65,944	33%
Aetna Better Health	1,241	231	19%	1,332	257	19%
Amerigroup	33,245	7,222	22%	35,736	8,995	25%
Blue Cross and Blue Shield of Texas	3,927	3,069	78%	4,363	3,430	79%
Community First Health Plans	2,129	70	3%	2,270	68	3%
Community Health Choice	7,858	4,470	57%	8,621	5,014	58%
Cook Children's Health Plan	3,041	0	0%	3,276	0	0%
Dell Children's Health Plan	2,333	1,865	80%	2,576	680	26%
Driscoll Health Plan	13,321	0	0%	14,050	0	0%
FirstCare	3,003	0	0%	3,152	0	0%
Molina Healthcare of Texas	2,799	348	12%	2,955	397	13%
Right Care from Scott and White Health Plans	3,612	0	0%	3,901	0	0%

## Attachment H2

Specialist Network Access Analysis SFY21  
(Blanks = No Data Available)

Program County Type MCO	Quarter 1			Quarter 2		
	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)
Superior HealthPlan	88,467	40,367	46%	93,457	43,198	46%
Texas Children's Health Plan	11,219	948	8%	12,373	3,534	29%
UnitedHealthcare Community Plan	10,450	1,567	15%	11,234	371	3%
Rural	250,417	146,824	59%	264,670	163,840	62%
Aetna Better Health	1,051	1,051	100%	1,163	1,163	100%
Amerigroup	48,183	26,710	55%	51,279	33,001	64%
Blue Cross and Blue Shield of Texas	1,611	1,611	100%	1,713	1,713	100%
Community First Health Plans	5,181	5,181	100%	5,493	5,493	100%
Community Health Choice	8,655	8,651	100%	8,997	8,996	100%
Dell Children's Health Plan	707	707	100%	742	738	99%
Driscoll Health Plan	17,241	1,668	10%	18,014	2,865	16%
El Paso First	15	15	100%	16	16	100%
FirstCare	27,311	0	0%	28,619	0	0%
Molina Healthcare of Texas	3,191	2,353	74%	3,315	2,502	75%
Parkland	659	659	100%	711	711	100%
Right Care from Scott and White Health Plans	8,413	0	0%	8,747	0	0%
Superior HealthPlan	111,822	86,446	77%	118,431	91,421	77%
Texas Children's Health Plan	10,004	6,441	64%	10,605	9,892	93%
UnitedHealthcare Community Plan	6,373	5,331	84%	6,825	5,329	78%
<b>STAR Total</b>	<b>3,148,901</b>	<b>2,166,771</b>	<b>69%</b>	<b>3,323,122</b>	<b>2,212,685</b>	<b>67%</b>
<b>STAR+PLUS</b>						
Metro	175,958	137,523	93%	175,925	130,873	93%
Amerigroup	46,755	32,369	100%	46,683	27,792	100%
Cigna-HealthSpring	11,341	7,800	100%	11,355	7,834	100%
Molina Healthcare of Texas	29,839	25,097	100%	29,844	25,390	100%
Superior HealthPlan	46,437	37,931	100%	46,281	37,791	100%
UnitedHealthcare Community Plan	41,586	34,326	100%	41,762	32,066	100%
Micro	14,707	6,300	100%	14,710	6,564	100%
Amerigroup	1,643	578	100%	1,629	355	100%
Cigna-HealthSpring	3,457	1,696	100%	3,433	1,684	100%
Molina Healthcare of Texas	600	180	100%	605	194	100%
Superior HealthPlan	2,825	1,641	100%	2,821	1,653	100%
UnitedHealthcare Community Plan	6,182	2,205	100%	6,222	2,678	100%
Rural	19,599	14,567	100%	19,652	14,983	100%
Amerigroup	3,489	1,467	100%	3,493	1,951	100%
Cigna-HealthSpring	1,618	1,501	100%	1,623	1,502	100%
Molina Healthcare of Texas	1,046	953	100%	1,024	940	100%
Superior HealthPlan	8,167	6,523	100%	8,182	6,542	100%
UnitedHealthcare Community Plan	5,279	4,123	100%	5,330	4,048	100%
<b>STAR+PLUS Total</b>	<b>210,264</b>	<b>158,390</b>	<b>100%</b>	<b>210,287</b>	<b>152,420</b>	<b>100%</b>
<b>STAR Kids</b>						
Metro	125,208	83,845	67%	127,622	81,399	64%
Aetna Better Health	4,444	843	19%	4,646	4,391	95%
Amerigroup	23,606	19,805	84%	24,409	16,586	68%
Blue Cross and Blue Shield of Texas	6,080	6,003	99%	6,213	6,129	99%
Community First Health Plans	6,812	5,155	76%	6,939	5,257	76%
Cook Children's Health Plan	8,979	0	0%	9,064	0	0%
Driscoll Health Plan	7,906	1,524	19%	8,006	1,973	25%
Superior HealthPlan	22,613	14,112	62%	23,006	14,320	62%
Texas Children's Health Plan	23,313	18,495	79%	23,666	20,139	85%
UnitedHealthcare Community Plan	21,455	17,908	83%	21,673	12,604	58%
Micro	8,119	2,765	34%	8,357	3,263	39%
Aetna Better Health	41	0	0%	43	0	0%
Amerigroup	270	219	81%	275	226	82%
Blue Cross and Blue Shield of Texas	620	249	40%	628	252	40%
Community First Health Plans	102	13	13%	107	15	14%
Cook Children's Health Plan	123	0	0%	121	0	0%
Driscoll Health Plan	488	0	0%	494	0	0%
Superior HealthPlan	1,461	851	58%	1,488	866	58%
Texas Children's Health Plan	2,201	543	25%	2,325	709	30%
UnitedHealthcare Community Plan	2,813	890	32%	2,876	1,195	42%
Rural	9,646	6,133	64%	9,861	6,607	67%

## Attachment H2

Specialist Network Access Analysis SFY21  
(Blanks = No Data Available)

Program County Type MCO	Quarter 1			Quarter 2		
	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)
Amerigroup	1,816	660	36%	1,849	927	50%
Blue Cross and Blue Shield of Texas	857	712	83%	879	728	83%
Community First Health Plans	245	245	100%	241	241	100%
Driscoll Health Plan	779	77	10%	786	126	16%
Superior HealthPlan	2,301	1,571	68%	2,356	1,615	69%
Texas Children's Health Plan	1,299	891	69%	1,349	1,133	84%
UnitedHealthcare Community Plan	2,349	1,977	84%	2,401	1,837	77%
<b>STAR Kids Total</b>	<b>142,973</b>	<b>92,743</b>	<b>65%</b>	<b>145,840</b>	<b>91,269</b>	<b>63%</b>
<b>TCM and MHR Total</b>	<b>3,502,138</b>	<b>2,417,904</b>	<b>69%</b>	<b>3,679,249</b>	<b>2,456,374</b>	
<b>General Surgeon</b>						
<b>STAR</b>						
Metro	2,711,839	2,513,948	93%	2,859,156	2,770,657	97%
Aetna Better Health	76,748	76,706	100%	82,593	82,553	100%
Amerigroup	504,573	497,922	99%	534,681	528,565	99%
Blue Cross and Blue Shield of Texas	31,241	30,400	97%	33,560	32,651	97%
Community First Health Plans	109,084	108,861	100%	115,611	115,373	100%
Community Health Choice	261,022	259,537	99%	275,223	273,695	99%
Cook Children's Health Plan	112,170	0	0%	117,811	113,456	96%
Dell Children's Health Plan	24,247	23,552	97%	25,982	25,081	97%
Driscoll Health Plan	135,505	134,581	99%	142,172	140,980	99%
El Paso First	67,556	67,543	100%	71,157	71,143	100%
FirstCare	42,834	11,182	26%	45,191	11,799	26%
Molina Healthcare of Texas	89,048	88,548	99%	93,005	92,484	99%
Parkland	167,303	162,399	97%	176,125	171,018	97%
Right Care from Scott and White Health Plans	33,371	20,940	63%	34,961	21,721	62%
Superior HealthPlan	551,871	535,330	97%	577,239	559,833	97%
Texas Children's Health Plan	366,002	360,012	98%	384,774	382,667	99%
UnitedHealthcare Community Plan	139,264	136,435	98%	149,071	147,638	99%
Micro	186,645	172,237	92%	199,296	182,650	92%
Aetna Better Health	1,241	1,239	100%	1,332	1,329	100%
Amerigroup	33,245	26,633	80%	35,736	30,747	86%
Blue Cross and Blue Shield of Texas	3,927	3,927	100%	4,363	4,363	100%
Community First Health Plans	2,129	2,125	100%	2,270	2,266	100%
Community Health Choice	7,858	7,858	100%	8,621	8,621	100%
Cook Children's Health Plan	3,041	0	0%	3,276	3,020	92%
Dell Children's Health Plan	2,333	2,262	97%	2,576	2,496	97%
Driscoll Health Plan	13,321	13,301	100%	14,050	14,024	100%
FirstCare	3,003	2,972	99%	3,152	3,122	99%
Molina Healthcare of Texas	2,799	2,794	100%	2,955	2,954	100%
Right Care from Scott and White Health Plans	3,612	3,612	100%	3,901	3,637	93%
Superior HealthPlan	88,467	83,994	95%	93,457	82,564	88%
Texas Children's Health Plan	11,219	11,131	99%	12,373	12,280	99%
UnitedHealthcare Community Plan	10,450	10,389	99%	11,234	11,227	100%
Rural	250,417	218,931	87%	264,670	230,996	87%
Aetna Better Health	1,051	1,051	100%	1,163	1,163	100%
Amerigroup	48,183	46,760	97%	51,279	50,087	98%
Blue Cross and Blue Shield of Texas	1,611	1,611	100%	1,713	1,713	100%
Community First Health Plans	5,181	5,181	100%	5,493	5,493	100%
Community Health Choice	8,655	8,600	99%	8,997	8,944	99%
Dell Children's Health Plan	707	707	100%	742	742	100%
Driscoll Health Plan	17,241	17,241	100%	18,014	17,999	100%
El Paso First	15	14	93%	16	15	94%
FirstCare	27,311	4,281	16%	28,619	4,466	16%
Molina Healthcare of Texas	3,191	3,156	99%	3,315	3,290	99%
Parkland	659	659	100%	711	711	100%
Right Care from Scott and White Health Plans	8,413	7,531	90%	8,747	7,656	88%
Superior HealthPlan	111,822	105,896	95%	118,431	111,553	94%
Texas Children's Health Plan	10,004	9,922	99%	10,605	10,517	99%
UnitedHealthcare Community Plan	6,373	6,321	99%	6,825	6,647	97%
<b>STAR Total</b>	<b>3,148,901</b>	<b>2,905,116</b>	<b>92%</b>	<b>3,323,122</b>	<b>3,184,303</b>	<b>96%</b>
<b>STAR+PLUS</b>						
Metro	175,958	171,656	98%	175,925	172,206	98%

## Attachment H2

Specialist Network Access Analysis SFY21  
(Blanks = No Data Available)

Program County Type MCO	Quarter 1			Quarter 2		
	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)
Amerigroup	46,755	46,373	99%	46,683	46,410	99%
Cigna-HealthSpring	11,341	11,055	97%	11,355	11,062	97%
Molina Healthcare of Texas	29,839	29,571	99%	29,844	29,569	99%
Superior HealthPlan	46,437	44,531	96%	46,281	44,387	96%
UnitedHealthcare Community Plan	41,586	40,126	96%	41,762	40,778	98%
Micro	14,707	14,302	97%	14,710	13,943	95%
Amerigroup	1,643	1,537	94%	1,629	1,523	93%
Cigna-HealthSpring	3,457	3,393	98%	3,433	3,049	89%
Molina Healthcare of Texas	600	598	100%	605	605	100%
Superior HealthPlan	2,825	2,679	95%	2,821	2,672	95%
UnitedHealthcare Community Plan	6,182	6,095	99%	6,222	6,094	98%
Rural	19,599	18,755	96%	19,652	18,798	96%
Amerigroup	3,489	3,328	95%	3,493	3,378	97%
Cigna-HealthSpring	1,618	1,612	100%	1,623	1,616	100%
Molina Healthcare of Texas	1,046	1,038	99%	1,024	1,018	99%
Superior HealthPlan	8,167	7,754	95%	8,182	7,730	94%
UnitedHealthcare Community Plan	5,279	5,023	95%	5,330	5,056	95%
<b>STAR+PLUS Total</b>	<b>210,264</b>	<b>204,713</b>	<b>97%</b>	<b>210,287</b>	<b>204,947</b>	<b>97%</b>
<b>STAR Kids</b>						
Metro	125,208	114,247	91%	127,622	125,213	98%
Aetna Better Health	4,444	4,444	100%	4,646	4,646	100%
Amerigroup	23,606	23,427	99%	24,409	24,219	99%
Blue Cross and Blue Shield of Texas	6,080	6,071	100%	6,213	6,202	100%
Community First Health Plans	6,812	6,780	100%	6,939	6,931	100%
Cook Children's Health Plan	8,979	0	0%	9,064	8,550	94%
Driscoll Health Plan	7,906	7,852	99%	8,006	7,946	99%
Superior HealthPlan	22,613	22,274	99%	23,006	22,665	99%
Texas Children's Health Plan	23,313	22,930	98%	23,666	23,270	98%
UnitedHealthcare Community Plan	21,455	20,469	95%	21,673	20,784	96%
Micro	8,119	7,744	95%	8,357	7,991	96%
Aetna Better Health	41	41	100%	43	43	100%
Amerigroup	270	270	100%	275	275	100%
Blue Cross and Blue Shield of Texas	620	618	100%	628	625	100%
Community First Health Plans	102	99	97%	107	107	100%
Cook Children's Health Plan	123	0	0%	121	103	85%
Driscoll Health Plan	488	487	100%	494	493	100%
Superior HealthPlan	1,461	1,321	90%	1,488	1,348	91%
Texas Children's Health Plan	2,201	2,170	99%	2,325	2,284	98%
UnitedHealthcare Community Plan	2,813	2,738	97%	2,876	2,713	94%
Rural	9,646	9,185	95%	9,861	9,382	95%
Amerigroup	1,816	1,738	96%	1,849	1,792	97%
Blue Cross and Blue Shield of Texas	857	853	100%	879	876	100%
Community First Health Plans	245	245	100%	241	241	100%
Driscoll Health Plan	779	779	100%	786	785	100%
Superior HealthPlan	2,301	2,137	93%	2,356	2,158	92%
Texas Children's Health Plan	1,299	1,288	99%	1,349	1,338	99%
UnitedHealthcare Community Plan	2,349	2,145	91%	2,401	2,192	91%
<b>STAR Kids Total</b>	<b>142,973</b>	<b>131,176</b>	<b>92%</b>	<b>145,840</b>	<b>142,586</b>	<b>98%</b>
<b>General Surgeon Total</b>	<b>3,502,138</b>	<b>3,241,005</b>	<b>93%</b>	<b>3,679,249</b>	<b>3,531,836</b>	<b>96%</b>
<b>Nursing Facility</b>						
<b>STAR+PLUS</b>						
Metro	182,875	182,875	100%	183,873	183,873	100%
Amerigroup	48,064	48,064	100%	48,457	48,457	100%
Cigna-HealthSpring	15,560	15,560	100%	15,517	15,517	100%
Molina Healthcare of Texas	36,970	36,970	100%	37,114	37,114	100%
Superior HealthPlan	42,748	42,748	100%	42,825	42,825	100%
UnitedHealthcare Community Plan	39,533	39,533	100%	39,960	39,960	100%
Micro	16,577	16,577	100%	16,608	16,608	100%
Amerigroup	1,936	1,936	100%	1,946	1,946	100%
Cigna-HealthSpring	3,912	3,912	100%	3,894	3,894	100%
Molina Healthcare of Texas	1,532	1,532	100%	1,531	1,531	100%
Superior HealthPlan	3,962	3,962	100%	3,933	3,933	100%

## Attachment H2

Specialist Network Access Analysis SFY21  
(Blanks = No Data Available)

Program County Type MCO	Quarter 1			Quarter 2		
	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)
UnitedHealthcare Community Plan	5,235	5,235	100%	5,304	5,304	100%
Rural	22,705	22,286	98%	22,725	22,309	98%
Amerigroup	5,490	5,244	96%	5,444	5,201	96%
Cigna-HealthSpring	1,590	1,590	100%	1,594	1,594	100%
Molina Healthcare of Texas	1,594	1,594	100%	1,574	1,574	100%
Superior HealthPlan	8,427	8,255	98%	8,488	8,316	98%
UnitedHealthcare Community Plan	5,604	5,603	100%	5,625	5,624	100%
<b>STAR+PLUS Total</b>	<b>222,157</b>	<b>221,738</b>	<b>100%</b>	<b>223,206</b>	<b>222,790</b>	<b>100%</b>
<b>Nursing Facility Total</b>	<b>222,157</b>	<b>221,738</b>	<b>100%</b>	<b>223,206</b>	<b>222,790</b>	<b>100%</b>
<b>OB/GYN</b>						
<b>STAR</b>						
Metro	640,229	633,220	99%	701,970	695,965	99%
Aetna Better Health	18,988	18,988	100%	21,337	21,337	100%
Amerigroup	119,585	119,434	100%	131,563	131,425	100%
Blue Cross and Blue Shield of Texas	7,684	7,684	100%	8,542	8,542	100%
Community First Health Plans	27,509	27,509	100%	30,207	30,207	100%
Community Health Choice	60,222	60,222	100%	66,188	66,188	100%
Cook Children's Health Plan	24,283	22,867	94%	26,732	26,707	100%
Dell Children's Health Plan	4,791	4,791	100%	5,439	5,439	100%
Driscoll Health Plan	31,065	31,065	100%	34,087	34,079	100%
El Paso First	16,702	16,702	100%	18,251	18,251	100%
FirstCare	10,327	5,916	57%	11,431	6,646	58%
Molina Healthcare of Texas	22,378	22,374	100%	24,164	24,160	100%
Parkland	38,273	38,177	100%	42,098	42,083	100%
Right Care from Scott and White Health Plans	8,277	8,269	100%	9,031	9,022	100%
Superior HealthPlan	136,613	135,691	99%	148,317	147,297	99%
Texas Children's Health Plan	76,914	76,914	100%	83,900	83,900	100%
UnitedHealthcare Community Plan	36,618	36,617	100%	40,683	40,682	100%
Micro	45,220	45,209	100%	49,984	49,973	100%
Aetna Better Health	339	339	100%	360	360	100%
Amerigroup	8,209	8,206	100%	9,166	9,163	100%
Blue Cross and Blue Shield of Texas	974	974	100%	1,099	1,099	100%
Community First Health Plans	487	487	100%	542	542	100%
Community Health Choice	1,882	1,882	100%	2,128	2,128	100%
Cook Children's Health Plan	654	654	100%	725	725	100%
Dell Children's Health Plan	447	447	100%	502	502	100%
Driscoll Health Plan	3,160	3,160	100%	3,443	3,443	100%
FirstCare	709	701	99%	781	773	99%
Molina Healthcare of Texas	728	728	100%	791	791	100%
Right Care from Scott and White Health Plans	904	904	100%	1,012	1,012	100%
Superior HealthPlan	21,639	21,639	100%	23,741	23,741	100%
Texas Children's Health Plan	2,360	2,360	100%	2,673	2,673	100%
UnitedHealthcare Community Plan	2,728	2,728	100%	3,021	3,021	100%
Rural	61,416	58,232	95%	67,479	63,984	95%
Aetna Better Health	278	278	100%	319	319	100%
Amerigroup	11,537	11,427	99%	12,724	12,603	99%
Blue Cross and Blue Shield of Texas	418	418	100%	454	454	100%
Community First Health Plans	1,363	1,363	100%	1,513	1,513	100%
Community Health Choice	2,042	2,042	100%	2,200	2,200	100%
Dell Children's Health Plan	157	157	100%	175	175	100%
Driscoll Health Plan	4,097	4,097	100%	4,456	4,456	100%
El Paso First	3	3	100%	4	4	100%
FirstCare	6,329	3,782	60%	7,014	4,236	60%
Molina Healthcare of Texas	820	820	100%	877	877	100%
Parkland	167	167	100%	178	178	100%
Right Care from Scott and White Health Plans	2,012	2,004	100%	2,193	2,172	99%
Superior HealthPlan	28,003	27,484	98%	30,747	30,172	98%
Texas Children's Health Plan	2,258	2,258	100%	2,467	2,467	100%
UnitedHealthcare Community Plan	1,932	1,932	100%	2,158	2,158	100%
<b>STAR Total</b>	<b>746,865</b>	<b>736,661</b>	<b>99%</b>	<b>819,433</b>	<b>809,922</b>	<b>99%</b>
<b>STAR+PLUS</b>						
Metro	86,120	85,837	100%	86,036	85,750	100%

## Attachment H2

Specialist Network Access Analysis SFY21  
(Blanks = No Data Available)

Program County Type MCO	Quarter 1			Quarter 2		
	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)
Amerigroup	22,851	22,851	100%	22,804	22,804	100%
Cigna-HealthSpring	5,499	5,480	100%	5,489	5,471	100%
Molina Healthcare of Texas	14,159	14,151	100%	14,173	14,163	100%
Superior HealthPlan	23,536	23,280	99%	23,448	23,190	99%
UnitedHealthcare Community Plan	20,075	20,075	100%	20,122	20,122	100%
Micro	7,655	7,654	100%	7,686	7,685	100%
Amerigroup	809	808	100%	799	798	100%
Cigna-HealthSpring	1,844	1,844	100%	1,837	1,837	100%
Molina Healthcare of Texas	283	283	100%	285	285	100%
Superior HealthPlan	1,519	1,519	100%	1,530	1,530	100%
UnitedHealthcare Community Plan	3,200	3,200	100%	3,235	3,235	100%
Rural	10,261	10,102	98%	10,271	10,115	98%
Amerigroup	1,799	1,779	99%	1,816	1,798	99%
Cigna-HealthSpring	825	825	100%	826	823	100%
Molina Healthcare of Texas	535	535	100%	516	516	100%
Superior HealthPlan	4,388	4,278	97%	4,391	4,285	98%
UnitedHealthcare Community Plan	2,714	2,685	99%	2,722	2,693	99%
<b>STAR+PLUS Total</b>	<b>104,036</b>	<b>103,593</b>	<b>100%</b>	<b>103,993</b>	<b>103,550</b>	<b>100%</b>
<b>STAR Kids</b>						
Metro	24,644	24,557	100%	25,528	25,474	100%
Aetna Better Health	939	939	100%	998	998	100%
Amerigroup	4,691	4,684	100%	4,944	4,937	100%
Blue Cross and Blue Shield of Texas	1,190	1,190	100%	1,236	1,236	100%
Community First Health Plans	1,332	1,332	100%	1,393	1,393	100%
Cook Children's Health Plan	1,758	1,727	98%	1,798	1,798	100%
Driscoll Health Plan	1,541	1,541	100%	1,566	1,566	100%
Superior HealthPlan	4,700	4,652	99%	4,836	4,790	99%
Texas Children's Health Plan	4,360	4,360	100%	4,478	4,478	100%
UnitedHealthcare Community Plan	4,133	4,132	100%	4,279	4,278	100%
Micro	1,610	1,610	100%	1,683	1,683	100%
Aetna Better Health	11	11	100%	11	11	100%
Amerigroup	62	62	100%	63	63	100%
Blue Cross and Blue Shield of Texas	129	129	100%	134	134	100%
Community First Health Plans	21	21	100%	23	23	100%
Cook Children's Health Plan	34	34	100%	33	33	100%
Driscoll Health Plan	98	98	100%	95	95	100%
Superior HealthPlan	287	287	100%	310	310	100%
Texas Children's Health Plan	399	399	100%	423	423	100%
UnitedHealthcare Community Plan	569	569	100%	591	591	100%
Rural	1,936	1,914	99%	1,995	1,975	99%
Amerigroup	367	363	99%	369	365	99%
Blue Cross and Blue Shield of Texas	174	174	100%	179	179	100%
Community First Health Plans	47	47	100%	48	48	100%
Driscoll Health Plan	138	138	100%	140	140	100%
Superior HealthPlan	472	464	98%	481	474	99%
Texas Children's Health Plan	236	236	100%	253	253	100%
UnitedHealthcare Community Plan	502	492	98%	525	516	98%
<b>STAR Kids Total</b>	<b>28,190</b>	<b>28,081</b>	<b>100%</b>	<b>29,206</b>	<b>29,132</b>	<b>100%</b>
<b>OB/GYN Total</b>	<b>879,091</b>	<b>868,335</b>	<b>99%</b>	<b>952,632</b>	<b>942,604</b>	<b>99%</b>
<b>Ophthalmologist</b>						
<b>STAR</b>						
Metro	2,711,839	2,577,418	95%	2,859,156	2,733,890	96%
Aetna Better Health	76,748	72,005	94%	82,593	77,460	94%
Amerigroup	504,573	486,826	96%	534,681	516,662	97%
Blue Cross and Blue Shield of Texas	31,241	31,140	100%	33,560	33,457	100%
Community First Health Plans	109,084	108,642	100%	115,611	115,134	100%
Community Health Choice	261,022	260,810	100%	275,223	275,010	100%
Cook Children's Health Plan	112,170	93,871	84%	117,811	112,332	95%
Dell Children's Health Plan	24,247	24,154	100%	25,982	25,895	100%
Driscoll Health Plan	135,505	134,461	99%	142,172	140,791	99%
El Paso First	67,556	67,537	100%	71,157	71,139	100%
FirstCare	42,834	0	0%	45,191	0	0%

## Attachment H2

Specialist Network Access Analysis SFY21  
(Blanks = No Data Available)

Program County Type MCO	Quarter 1			Quarter 2		
	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)
Molina Healthcare of Texas	89,048	87,823	99%	93,005	91,670	99%
Parkland	167,303	153,849	92%	176,125	161,924	92%
Right Care from Scott and White Health Plans	33,371	12,148	36%	34,961	12,617	36%
Superior HealthPlan	551,871	542,574	98%	577,239	567,193	98%
Texas Children's Health Plan	366,002	365,767	100%	384,774	384,495	100%
UnitedHealthcare Community Plan	139,264	135,811	98%	149,071	148,111	99%
Micro	186,645	154,755	83%	199,296	159,432	80%
Aetna Better Health	1,241	1,066	86%	1,332	1,145	86%
Amerigroup	33,245	24,532	74%	35,736	26,329	74%
Blue Cross and Blue Shield of Texas	3,927	3,664	93%	4,363	4,091	94%
Community First Health Plans	2,129	2,122	100%	2,270	2,262	100%
Community Health Choice	7,858	7,799	99%	8,621	8,544	99%
Cook Children's Health Plan	3,041	1,441	47%	3,276	2,817	86%
Dell Children's Health Plan	2,333	2,219	95%	2,576	2,459	95%
Driscoll Health Plan	13,321	11,575	87%	14,050	11,664	83%
FirstCare	3,003	0	0%	3,152	0	0%
Molina Healthcare of Texas	2,799	1,259	45%	2,955	1,258	43%
Right Care from Scott and White Health Plans	3,612	3,450	96%	3,901	3,717	95%
Superior HealthPlan	88,467	75,419	85%	93,457	73,149	78%
Texas Children's Health Plan	11,219	11,137	99%	12,373	12,291	99%
UnitedHealthcare Community Plan	10,450	9,072	87%	11,234	9,706	86%
Rural	250,417	204,763	82%	264,670	215,626	81%
Aetna Better Health	1,051	1,051	100%	1,163	1,163	100%
Amerigroup	48,183	44,102	92%	51,279	46,760	91%
Blue Cross and Blue Shield of Texas	1,611	1,611	100%	1,713	1,713	100%
Community First Health Plans	5,181	5,181	100%	5,493	5,493	100%
Community Health Choice	8,655	8,593	99%	8,997	8,930	99%
Dell Children's Health Plan	707	661	93%	742	702	95%
Driscoll Health Plan	17,241	17,116	99%	18,014	17,850	99%
El Paso First	15	14	93%	16	15	94%
FirstCare	27,311	0	0%	28,619	0	0%
Molina Healthcare of Texas	3,191	3,153	99%	3,315	3,279	99%
Parkland	659	651	99%	711	702	99%
Right Care from Scott and White Health Plans	8,413	7,071	84%	8,747	7,364	84%
Superior HealthPlan	111,822	99,461	89%	118,431	104,533	88%
Texas Children's Health Plan	10,004	9,942	99%	10,605	10,538	99%
UnitedHealthcare Community Plan	6,373	6,156	97%	6,825	6,584	96%
<b>STAR Total</b>	<b>3,148,901</b>	<b>2,936,936</b>	<b>93%</b>	<b>3,323,122</b>	<b>3,108,948</b>	<b>94%</b>
<b>STAR+PLUS</b>						
Metro	175,958	171,403	97%	175,925	172,377	98%
Amerigroup	46,755	46,189	99%	46,683	46,125	99%
Cigna-HealthSpring	11,341	10,539	93%	11,355	10,625	94%
Molina Healthcare of Texas	29,839	29,210	98%	29,844	29,181	98%
Superior HealthPlan	46,437	45,505	98%	46,281	45,784	99%
UnitedHealthcare Community Plan	41,586	39,960	96%	41,762	40,662	97%
Micro	14,707	12,513	85%	14,710	12,410	84%
Amerigroup	1,643	1,478	90%	1,629	1,461	90%
Cigna-HealthSpring	3,457	2,588	75%	3,433	2,545	74%
Molina Healthcare of Texas	600	450	75%	605	446	74%
Superior HealthPlan	2,825	2,662	94%	2,821	2,349	83%
UnitedHealthcare Community Plan	6,182	5,335	86%	6,222	5,609	90%
Rural	19,599	18,004	92%	19,652	18,055	92%
Amerigroup	3,489	3,192	91%	3,493	3,201	92%
Cigna-HealthSpring	1,618	1,527	94%	1,623	1,534	95%
Molina Healthcare of Texas	1,046	1,037	99%	1,024	1,016	99%
Superior HealthPlan	8,167	7,337	90%	8,182	7,355	90%
UnitedHealthcare Community Plan	5,279	4,911	93%	5,330	4,949	93%
<b>STAR+PLUS Total</b>	<b>210,264</b>	<b>201,920</b>	<b>96%</b>	<b>210,287</b>	<b>202,842</b>	<b>96%</b>
<b>STAR Kids</b>						
Metro	125,208	119,435	95%	127,622	123,977	97%
Aetna Better Health	4,444	4,076	92%	4,646	4,267	92%
Amerigroup	23,606	22,805	97%	24,409	23,631	97%



## Attachment H2

Specialist Network Access Analysis SFY21  
(Blanks = No Data Available)

Program County Type MCO	Quarter 1			Quarter 2		
	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)
Blue Cross and Blue Shield of Texas	6,080	5,384	89%	6,213	5,511	89%
Community First Health Plans	6,812	6,790	100%	6,939	6,916	100%
Cook Children's Health Plan	8,979	7,293	81%	9,064	8,515	94%
Driscoll Health Plan	7,906	7,850	99%	8,006	7,932	99%
Superior HealthPlan	22,613	22,566	100%	23,006	22,950	100%
Texas Children's Health Plan	23,313	22,132	95%	23,666	22,889	97%
UnitedHealthcare Community Plan	21,455	20,539	96%	21,673	21,366	99%
Micro	8,119	6,800	84%	8,357	6,869	82%
Aetna Better Health	41	35	85%	43	36	84%
Amerigroup	270	245	91%	275	251	91%
Blue Cross and Blue Shield of Texas	620	588	95%	628	599	95%
Community First Health Plans	102	99	97%	107	104	97%
Cook Children's Health Plan	123	64	52%	121	99	82%
Driscoll Health Plan	488	448	92%	494	425	86%
Superior HealthPlan	1,461	1,320	90%	1,488	1,046	70%
Texas Children's Health Plan	2,201	1,623	74%	2,325	1,720	74%
UnitedHealthcare Community Plan	2,813	2,378	85%	2,876	2,589	90%
Rural	9,646	8,791	91%	9,861	9,001	91%
Amerigroup	1,816	1,632	90%	1,849	1,662	90%
Blue Cross and Blue Shield of Texas	857	769	90%	879	788	90%
Community First Health Plans	245	245	100%	241	241	100%
Driscoll Health Plan	779	777	100%	786	784	100%
Superior HealthPlan	2,301	1,942	84%	2,356	1,993	85%
Texas Children's Health Plan	1,299	1,249	96%	1,349	1,304	97%
UnitedHealthcare Community Plan	2,349	2,177	93%	2,401	2,229	93%
<b>STAR Kids Total</b>	<b>142,973</b>	<b>135,026</b>	<b>94%</b>	<b>145,840</b>	<b>139,847</b>	<b>96%</b>
<b>Ophthalmologist Total</b>	<b>3,502,138</b>	<b>3,273,882</b>	<b>93%</b>	<b>3,679,249</b>	<b>3,451,637</b>	<b>94%</b>
<b>Orthopedist</b>						
<b>STAR</b>						
Metro	2,711,839	2,604,361	96%	2,859,156	2,759,657	97%
Aetna Better Health	76,748	75,601	99%	82,593	81,470	99%
Amerigroup	504,573	490,569	97%	534,681	526,209	98%
Blue Cross and Blue Shield of Texas	31,241	30,320	97%	33,560	32,549	97%
Community First Health Plans	109,084	108,888	100%	115,611	115,399	100%
Community Health Choice	261,022	260,681	100%	275,223	274,867	100%
Cook Children's Health Plan	112,170	96,605	86%	117,811	110,646	94%
Dell Children's Health Plan	24,247	23,333	96%	25,982	25,114	97%
Driscoll Health Plan	135,505	134,665	99%	142,172	141,308	99%
El Paso First	67,556	67,546	100%	71,157	71,146	100%
FirstCare	42,834	0	0%	45,191	0	0%
Molina Healthcare of Texas	89,048	87,613	98%	93,005	91,511	98%
Parkland	167,303	154,924	93%	176,125	162,947	93%
Right Care from Scott and White Health Plans	33,371	27,972	84%	34,961	27,342	78%
Superior HealthPlan	551,871	542,069	98%	577,239	566,882	98%
Texas Children's Health Plan	366,002	365,321	100%	384,774	384,042	100%
UnitedHealthcare Community Plan	139,264	138,254	99%	149,071	148,225	99%
Micro	186,645	149,061	80%	199,296	162,913	82%
Aetna Better Health	1,241	1,186	96%	1,332	1,271	95%
Amerigroup	33,245	27,966	84%	35,736	32,272	90%
Blue Cross and Blue Shield of Texas	3,927	3,683	94%	4,363	4,114	94%
Community First Health Plans	2,129	2,129	100%	2,270	2,270	100%
Community Health Choice	7,858	7,858	100%	8,621	8,621	100%
Cook Children's Health Plan	3,041	1,301	43%	3,276	2,799	85%
Dell Children's Health Plan	2,333	2,333	100%	2,576	2,496	97%
Driscoll Health Plan	13,321	9,321	70%	14,050	9,900	70%
FirstCare	3,003	0	0%	3,152	0	0%
Molina Healthcare of Texas	2,799	1,207	43%	2,955	1,283	43%
Right Care from Scott and White Health Plans	3,612	3,195	88%	3,901	3,650	94%
Superior HealthPlan	88,467	70,628	80%	93,457	73,506	79%
Texas Children's Health Plan	11,219	10,822	96%	12,373	11,927	96%
UnitedHealthcare Community Plan	10,450	7,432	71%	11,234	8,804	78%
Rural	250,417	203,467	81%	264,670	216,476	82%



## Attachment H2

Specialist Network Access Analysis SFY21  
(Blanks = No Data Available)

Program County Type MCO	Quarter 1			Quarter 2		
	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)
Aetna Better Health	1,051	1,051	100%	1,163	1,163	100%
Amerigroup	48,183	43,231	90%	51,279	47,162	92%
Blue Cross and Blue Shield of Texas	1,611	1,611	100%	1,713	1,713	100%
Community First Health Plans	5,181	5,181	100%	5,493	5,493	100%
Community Health Choice	8,655	8,530	99%	8,997	8,862	98%
Dell Children's Health Plan	707	707	100%	742	742	100%
Driscoll Health Plan	17,241	17,208	100%	18,014	17,977	100%
El Paso First	15	14	93%	16	15	94%
FirstCare	27,311	0	0%	28,619	0	0%
Molina Healthcare of Texas	3,191	3,100	97%	3,315	3,225	97%
Parkland	659	643	98%	711	690	97%
Right Care from Scott and White Health Plans	8,413	7,637	91%	8,747	8,225	94%
Superior HealthPlan	111,822	99,366	89%	118,431	105,026	89%
Texas Children's Health Plan	10,004	9,059	91%	10,605	9,628	91%
UnitedHealthcare Community Plan	6,373	6,129	96%	6,825	6,555	96%
<b>STAR Total</b>	<b>3,148,901</b>	<b>2,956,889</b>	<b>94%</b>	<b>3,323,122</b>	<b>3,139,046</b>	<b>94%</b>
<b>STAR+PLUS</b>						
Metro	175,958	170,814	97%	175,925	170,894	97%
Amerigroup	46,755	45,166	97%	46,683	45,243	97%
Cigna-HealthSpring	11,341	10,750	95%	11,355	10,790	95%
Molina Healthcare of Texas	29,839	28,994	97%	29,844	28,993	97%
Superior HealthPlan	46,437	45,232	97%	46,281	45,073	97%
UnitedHealthcare Community Plan	41,586	40,672	98%	41,762	40,795	98%
Micro	14,707	13,242	90%	14,710	12,586	86%
Amerigroup	1,643	1,444	88%	1,629	1,437	88%
Cigna-HealthSpring	3,457	3,029	88%	3,433	2,610	76%
Molina Healthcare of Texas	600	414	69%	605	420	69%
Superior HealthPlan	2,825	2,310	82%	2,821	2,238	79%
UnitedHealthcare Community Plan	6,182	6,045	98%	6,222	5,881	95%
Rural	19,599	17,337	88%	19,652	17,553	89%
Amerigroup	3,489	2,753	79%	3,493	2,917	84%
Cigna-HealthSpring	1,618	1,528	94%	1,623	1,536	95%
Molina Healthcare of Texas	1,046	1,029	98%	1,024	1,008	98%
Superior HealthPlan	8,167	7,262	89%	8,182	7,271	89%
UnitedHealthcare Community Plan	5,279	4,765	90%	5,330	4,821	90%
<b>STAR+PLUS Total</b>	<b>210,264</b>	<b>201,393</b>	<b>96%</b>	<b>210,287</b>	<b>201,033</b>	<b>96%</b>
<b>STAR Kids</b>						
Metro	125,208	121,143	97%	127,622	124,433	98%
Aetna Better Health	4,444	4,378	99%	4,646	4,602	99%
Amerigroup	23,606	23,428	99%	24,409	24,226	99%
Blue Cross and Blue Shield of Texas	6,080	5,909	97%	6,213	6,027	97%
Community First Health Plans	6,812	6,809	100%	6,939	6,933	100%
Cook Children's Health Plan	8,979	7,658	85%	9,064	8,626	95%
Driscoll Health Plan	7,906	7,856	99%	8,006	7,959	99%
Superior HealthPlan	22,613	21,333	94%	23,006	21,707	94%
Texas Children's Health Plan	23,313	22,710	97%	23,666	23,088	98%
UnitedHealthcare Community Plan	21,455	21,062	98%	21,673	21,265	98%
Micro	8,119	7,082	87%	8,357	7,218	86%
Aetna Better Health	41	38	93%	43	38	88%
Amerigroup	270	270	100%	275	275	100%
Blue Cross and Blue Shield of Texas	620	588	95%	628	599	95%
Community First Health Plans	102	102	100%	107	107	100%
Cook Children's Health Plan	123	61	50%	121	105	87%
Driscoll Health Plan	488	396	81%	494	405	82%
Superior HealthPlan	1,461	1,009	69%	1,488	1,014	68%
Texas Children's Health Plan	2,201	2,047	93%	2,325	2,160	93%
UnitedHealthcare Community Plan	2,813	2,571	91%	2,876	2,515	87%
Rural	9,646	8,604	89%	9,861	8,817	89%
Amerigroup	1,816	1,636	90%	1,849	1,693	92%
Blue Cross and Blue Shield of Texas	857	857	100%	879	879	100%
Community First Health Plans	245	245	100%	241	241	100%
Driscoll Health Plan	779	778	100%	786	785	100%

## Attachment H2

Specialist Network Access Analysis SFY21  
(Blanks = No Data Available)

Program County Type MCO	Quarter 1			Quarter 2		
	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)
Superior HealthPlan	2,301	1,872	81%	2,356	1,922	82%
Texas Children's Health Plan	1,299	1,206	93%	1,349	1,256	93%
UnitedHealthcare Community Plan	2,349	2,010	86%	2,401	2,041	85%
<b>STAR Kids Total</b>	<b>142,973</b>	<b>136,829</b>	<b>96%</b>	<b>145,840</b>	<b>140,468</b>	<b>96%</b>
<b>Orthopedist Total</b>	<b>3,502,138</b>	<b>3,295,111</b>	<b>94%</b>	<b>3,679,249</b>	<b>3,480,547</b>	<b>95%</b>
<b>Pediatric Sub-Specialty</b>						
<b>STAR</b>						
Metro	2,337,339	2,023,064	87%	2,426,896	2,176,511	90%
Aetna Better Health	63,193	61,914	98%	66,943	65,568	98%
Amerigroup	437,933	399,481	91%	456,999	416,498	91%
Blue Cross and Blue Shield of Texas	26,029	25,916	100%	27,527	27,391	100%
Community First Health Plans	93,036	0	0%	97,063	0	0%
Community Health Choice	223,103	222,997	100%	231,737	231,637	100%
Cook Children's Health Plan	99,574	18,017	18%	103,024	98,817	96%
Dell Children's Health Plan	21,807	21,310	98%	23,057	22,132	96%
Driscoll Health Plan	116,736	116,733	100%	120,520	120,517	100%
El Paso First	57,783	57,783	100%	59,825	59,825	100%
FirstCare	36,489	16,093	44%	37,801	15,770	42%
Molina Healthcare of Texas	75,603	74,891	99%	77,764	77,499	100%
Parkland	146,161	140,970	96%	151,454	146,215	97%
Right Care from Scott and White Health Plans	27,943	23,481	84%	28,801	24,106	84%
Superior HealthPlan	468,966	404,589	86%	482,864	413,303	86%
Texas Children's Health Plan	329,959	325,886	99%	342,674	338,412	99%
UnitedHealthcare Community Plan	113,024	113,003	100%	118,843	118,821	100%
Micro	159,054	108,423	68%	167,537	112,086	67%
Aetna Better Health	986	960	97%	1,051	1,019	97%
Amerigroup	28,330	15,999	56%	30,066	17,282	57%
Blue Cross and Blue Shield of Texas	3,327	3,101	93%	3,646	3,424	94%
Community First Health Plans	1,827	0	0%	1,919	0	0%
Community Health Choice	6,715	6,715	100%	7,282	7,282	100%
Cook Children's Health Plan	2,675	0	0%	2,852	2,553	90%
Dell Children's Health Plan	2,108	1,942	92%	2,291	2,105	92%
Driscoll Health Plan	11,409	11,409	100%	11,884	11,884	100%
FirstCare	2,604	2,580	99%	2,681	2,660	99%
Molina Healthcare of Texas	2,374	2,051	86%	2,479	2,141	86%
Right Care from Scott and White Health Plans	2,990	2,989	100%	3,184	3,183	100%
Superior HealthPlan	75,103	42,143	56%	78,191	38,612	49%
Texas Children's Health Plan	10,051	9,979	99%	10,958	10,888	99%
UnitedHealthcare Community Plan	8,555	8,555	100%	9,053	9,053	100%
Rural	212,412	175,450	83%	221,013	178,675	81%
Aetna Better Health	878	878	100%	957	957	100%
Amerigroup	41,101	33,710	82%	43,094	35,344	82%
Blue Cross and Blue Shield of Texas	1,350	1,350	100%	1,409	1,409	100%
Community First Health Plans	4,385	0	0%	4,553	0	0%
Community Health Choice	7,436	7,436	100%	7,616	7,616	100%
Dell Children's Health Plan	630	630	100%	648	648	100%
Driscoll Health Plan	14,781	14,781	100%	15,216	15,216	100%
El Paso First	14	14	100%	15	15	100%
FirstCare	23,656	11,752	50%	24,339	12,079	50%
Molina Healthcare of Texas	2,657	2,654	100%	2,714	2,711	100%
Parkland	556	556	100%	590	590	100%
Right Care from Scott and White Health Plans	7,123	7,100	100%	7,264	7,242	100%
Superior HealthPlan	94,142	80,886	86%	98,253	80,503	82%
Texas Children's Health Plan	8,833	8,833	100%	9,271	9,271	100%
UnitedHealthcare Community Plan	4,870	4,870	100%	5,074	5,074	100%
<b>STAR Total</b>	<b>2,708,805</b>	<b>2,306,937</b>	<b>85%</b>	<b>2,815,446</b>	<b>2,467,272</b>	<b>88%</b>
<b>STAR Kids</b>						
Metro	102,942	87,234	85%	103,118	92,905	90%
Aetna Better Health	3,450	3,340	97%	3,547	3,444	97%
Amerigroup	19,340	18,393	95%	19,641	18,477	94%
Blue Cross and Blue Shield of Texas	4,955	3,773	76%	4,994	3,824	77%
Community First Health Plans	5,603	0	0%	5,608	0	0%

## Attachment H2

Specialist Network Access Analysis SFY21  
(Blanks = No Data Available)

Program County Type MCO	Quarter 1			Quarter 2		
	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)
Cook Children's Health Plan	7,431	1,408	19%	7,395	7,082	96%
Driscoll Health Plan	6,539	6,539	100%	6,518	6,518	100%
Superior HealthPlan	18,490	17,386	94%	18,453	17,316	94%
Texas Children's Health Plan	19,619	19,065	97%	19,595	19,054	97%
UnitedHealthcare Community Plan	17,515	17,330	99%	17,367	17,190	99%
Micro	6,576	5,047	77%	6,671	5,188	78%
Aetna Better Health	25	24	96%	24	22	92%
Amerigroup	216	21	10%	217	19	9%
Blue Cross and Blue Shield of Texas	493	455	92%	490	458	93%
Community First Health Plans	68	0	0%	72	0	0%
Cook Children's Health Plan	93	0	0%	91	83	91%
Driscoll Health Plan	395	395	100%	391	391	100%
Superior HealthPlan	1,196	473	40%	1,205	485	40%
Texas Children's Health Plan	1,859	1,448	78%	1,941	1,492	77%
UnitedHealthcare Community Plan	2,231	2,231	100%	2,240	2,238	100%
Rural	7,824	6,626	85%	7,870	6,654	85%
Amerigroup	1,488	1,112	75%	1,495	1,093	73%
Blue Cross and Blue Shield of Texas	683	646	95%	693	655	95%
Community First Health Plans	203	0	0%	199	0	0%
Driscoll Health Plan	645	645	100%	639	639	100%
Superior HealthPlan	1,862	1,280	69%	1,869	1,292	69%
Texas Children's Health Plan	1,095	1,095	100%	1,124	1,124	100%
UnitedHealthcare Community Plan	1,848	1,848	100%	1,851	1,851	100%
<b>STAR Kids Total</b>	<b>117,342</b>	<b>98,907</b>	<b>84%</b>	<b>117,659</b>	<b>104,747</b>	<b>89%</b>
<b>Pediatric Sub-specialty Total</b>	<b>2,826,147</b>	<b>2,405,844</b>	<b>85%</b>	<b>2,933,105</b>	<b>2,572,019</b>	<b>88%</b>
<b>Prenatal</b>						
<b>STAR</b>						
Metro	443,357	429,723	97%	495,095	482,581	97%
Aetna Better Health	14,278	14,078	99%	16,168	15,956	99%
Amerigroup	80,697	78,267	97%	90,875	88,299	97%
Blue Cross and Blue Shield of Texas	5,567	5,439	98%	6,319	6,167	98%
Community First Health Plans	18,960	18,456	97%	21,239	20,602	97%
Community Health Choice	43,387	43,241	100%	48,397	48,255	100%
Cook Children's Health Plan	16,082	13,020	81%	18,058	17,299	96%
Dell Children's Health Plan	3,006	2,969	99%	3,476	3,418	98%
Driscoll Health Plan	22,279	22,191	100%	24,867	24,801	100%
El Paso First	11,844	11,454	97%	13,234	13,096	99%
FirstCare	7,434	6,699	90%	8,379	7,477	89%
Molina Healthcare of Texas	15,342	15,172	99%	16,895	16,675	99%
Parkland	26,314	25,282	96%	29,497	28,380	96%
Right Care from Scott and White Health Plans	6,065	5,718	94%	6,739	6,357	94%
Superior HealthPlan	96,149	92,276	96%	106,204	101,586	96%
Texas Children's Health Plan	48,756	48,358	99%	54,195	53,766	99%
UnitedHealthcare Community Plan	27,197	27,103	100%	30,553	30,447	100%
Micro	31,833	30,658	96%	35,768	34,703	97%
Aetna Better Health	255	254	100%	281	280	100%
Amerigroup	5,587	5,534	99%	6,312	6,259	99%
Blue Cross and Blue Shield of Texas	691	691	100%	775	775	100%
Community First Health Plans	350	345	99%	404	324	80%
Community Health Choice	1,314	1,314	100%	1,525	1,524	100%
Cook Children's Health Plan	444	67	15%	487	476	98%
Dell Children's Health Plan	271	271	100%	317	317	100%
Driscoll Health Plan	2,233	2,231	100%	2,459	2,456	100%
FirstCare	496	490	99%	559	552	99%
Molina Healthcare of Texas	494	493	100%	549	548	100%
Right Care from Scott and White Health Plans	659	659	100%	748	748	100%
Superior HealthPlan	15,494	14,797	96%	17,333	16,434	95%
Texas Children's Health Plan	1,535	1,504	98%	1,764	1,758	100%
UnitedHealthcare Community Plan	2,010	2,008	100%	2,255	2,252	100%
Rural	43,581	36,421	84%	48,723	41,027	84%
Aetna Better Health	197	197	100%	222	222	100%
Amerigroup	8,115	7,500	92%	9,084	8,388	92%

## Attachment H2

Specialist Network Access Analysis SFY21  
(Blanks = No Data Available)

Program County Type MCO	Quarter 1			Quarter 2		
	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)
Blue Cross and Blue Shield of Texas	295	294	100%	321	319	99%
Community First Health Plans	933	925	99%	1,049	1,040	99%
Community Health Choice	1,463	1,463	100%	1,615	1,615	100%
Dell Children's Health Plan	99	97	98%	109	107	98%
Driscoll Health Plan	2,883	2,879	100%	3,190	3,103	97%
El Paso First	1	0	0%	1	0	0%
FirstCare	4,341	1,638	38%	4,932	2,226	45%
Molina Healthcare of Texas	597	568	95%	649	617	95%
Parkland	124	118	95%	134	127	95%
Right Care from Scott and White Health Plans	1,392	1,314	94%	1,549	1,466	95%
Superior HealthPlan	20,109	16,412	82%	22,462	18,391	82%
Texas Children's Health Plan	1,497	1,497	100%	1,668	1,668	100%
UnitedHealthcare Community Plan	1,535	1,519	99%	1,738	1,738	100%
<b>STAR Total</b>	<b>518,771</b>	<b>496,802</b>	<b>96%</b>	<b>579,586</b>	<b>558,311</b>	<b>96%</b>
<b>STAR+PLUS</b>						
Metro	35,749	34,940	98%	35,617	34,777	98%
Amerigroup	9,234	9,098	99%	9,165	8,998	98%
Cigna-HealthSpring	2,349	2,267	97%	2,329	2,247	96%
Molina Healthcare of Texas	5,696	5,587	98%	5,702	5,602	98%
Superior HealthPlan	10,036	9,631	96%	9,989	9,578	96%
UnitedHealthcare Community Plan	8,434	8,357	99%	8,432	8,352	99%
Micro	2,754	2,706	98%	2,750	2,679	97%
Amerigroup	277	264	95%	270	259	96%
Cigna-HealthSpring	656	655	100%	651	651	100%
Molina Healthcare of Texas	97	97	100%	93	93	100%
Superior HealthPlan	548	514	94%	553	493	89%
UnitedHealthcare Community Plan	1,176	1,176	100%	1,183	1,183	100%
Rural	3,596	3,173	88%	3,556	3,145	88%
Amerigroup	626	536	86%	620	523	84%
Cigna-HealthSpring	288	273	95%	285	272	95%
Molina Healthcare of Texas	171	159	93%	165	153	93%
Superior HealthPlan	1,543	1,237	80%	1,534	1,245	81%
UnitedHealthcare Community Plan	968	968	100%	952	952	100%
<b>STAR+PLUS Total</b>	<b>42,099</b>	<b>40,819</b>	<b>97%</b>	<b>41,923</b>	<b>40,601</b>	<b>97%</b>
<b>STAR Kids</b>						
Metro	16,491	15,981	97%	17,330	16,988	98%
Aetna Better Health	650	643	99%	690	683	99%
Amerigroup	3,126	3,028	97%	3,344	3,250	97%
Blue Cross and Blue Shield of Texas	801	777	97%	844	819	97%
Community First Health Plans	895	879	98%	943	919	97%
Cook Children's Health Plan	1,147	952	83%	1,196	1,164	97%
Driscoll Health Plan	1,055	1,049	99%	1,089	1,083	99%
Superior HealthPlan	3,154	3,065	97%	3,298	3,207	97%
Texas Children's Health Plan	2,840	2,790	98%	2,972	2,927	98%
UnitedHealthcare Community Plan	2,823	2,798	99%	2,954	2,936	99%
Micro	1,083	1,052	97%	1,151	1,136	99%
Aetna Better Health	8	8	100%	8	8	100%
Amerigroup	44	44	100%	44	44	100%
Blue Cross and Blue Shield of Texas	87	86	99%	91	90	99%
Community First Health Plans	18	18	100%	20	17	85%
Cook Children's Health Plan	23	3	13%	24	23	96%
Driscoll Health Plan	61	61	100%	59	59	100%
Superior HealthPlan	195	185	95%	212	202	95%
Texas Children's Health Plan	254	254	100%	267	267	100%
UnitedHealthcare Community Plan	393	393	100%	426	426	100%
Rural	1,330	1,237	93%	1,397	1,295	93%
Amerigroup	251	237	94%	263	245	93%
Blue Cross and Blue Shield of Texas	125	124	99%	130	129	99%
Community First Health Plans	34	34	100%	37	37	100%
Driscoll Health Plan	98	98	100%	98	96	98%
Superior HealthPlan	321	243	76%	332	253	76%
Texas Children's Health Plan	150	150	100%	167	165	99%

## Attachment H2

Specialist Network Access Analysis SFY21  
(Blanks = No Data Available)

Program County Type MCO	Quarter 1			Quarter 2		
	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)
UnitedHealthcare Community Plan	351	351	100%	370	370	100%
<b>STAR Kids Total</b>	<b>18,904</b>	<b>18,270</b>	97%	<b>19,878</b>	<b>19,419</b>	98%
<b>Prenatal Total</b>	<b>579,774</b>	<b>555,891</b>	96%	<b>641,387</b>	<b>618,331</b>	96%
<b>Psychiatrist</b>						
<b>STAR</b>						
Metro	2,711,839	2,588,314	95%	2,859,156	2,722,032	95%
Aetna Better Health	76,748	76,645	100%	82,593	82,478	100%
Amerigroup	504,573	503,660	100%	534,681	533,422	100%
Blue Cross and Blue Shield of Texas	31,241	31,240	100%	33,560	33,559	100%
Community First Health Plans	109,084	108,603	100%	115,611	115,117	100%
Community Health Choice	261,022	261,022	100%	275,223	275,223	100%
Cook Children's Health Plan	112,170	109,368	98%	117,811	115,257	98%
Dell Children's Health Plan	24,247	24,247	100%	25,982	25,982	100%
Driscoll Health Plan	135,505	115,146	85%	142,172	120,892	85%
El Paso First	67,556	67,555	100%	71,157	71,154	100%
FirstCare	42,834	52	0%	45,191	0	0%
Molina Healthcare of Texas	89,048	88,803	100%	93,005	92,779	100%
Parkland	167,303	167,303	100%	176,125	176,125	100%
Right Care from Scott and White Health Plans	33,371	28,065	84%	34,961	29,285	84%
Superior HealthPlan	551,871	501,343	91%	577,239	517,190	90%
Texas Children's Health Plan	366,002	366,002	100%	384,774	384,774	100%
UnitedHealthcare Community Plan	139,264	139,260	100%	149,071	148,795	100%
Micro	186,645	146,803	79%	199,296	151,025	76%
Aetna Better Health	1,241	1,241	100%	1,332	1,332	100%
Amerigroup	33,245	31,339	94%	35,736	33,719	94%
Blue Cross and Blue Shield of Texas	3,927	3,927	100%	4,363	4,363	100%
Community First Health Plans	2,129	2,129	100%	2,270	2,270	100%
Community Health Choice	7,858	7,857	100%	8,621	8,620	100%
Cook Children's Health Plan	3,041	2,713	89%	3,276	3,276	100%
Dell Children's Health Plan	2,333	2,333	100%	2,576	2,576	100%
Driscoll Health Plan	13,321	10,046	75%	14,050	10,655	76%
FirstCare	3,003	0	0%	3,152	0	0%
Molina Healthcare of Texas	2,799	1,568	56%	2,955	1,665	56%
Right Care from Scott and White Health Plans	3,612	2,615	72%	3,901	2,828	72%
Superior HealthPlan	88,467	61,130	69%	93,457	58,074	62%
Texas Children's Health Plan	11,219	11,218	100%	12,373	12,372	100%
UnitedHealthcare Community Plan	10,450	8,687	83%	11,234	9,275	83%
Rural	250,417	194,275	78%	264,670	198,163	75%
Aetna Better Health	1,051	1,051	100%	1,163	1,163	100%
Amerigroup	48,183	44,277	92%	51,279	48,090	94%
Blue Cross and Blue Shield of Texas	1,611	1,583	98%	1,713	1,673	98%
Community First Health Plans	5,181	5,181	100%	5,493	5,493	100%
Community Health Choice	8,655	8,620	100%	8,997	8,956	100%
Dell Children's Health Plan	707	661	93%	742	695	94%
Driscoll Health Plan	17,241	16,518	96%	18,014	17,247	96%
El Paso First	15	14	93%	16	15	94%
FirstCare	27,311	6,895	25%	28,619	0	0%
Molina Healthcare of Texas	3,191	3,151	99%	3,315	3,280	99%
Parkland	659	659	100%	711	711	100%
Right Care from Scott and White Health Plans	8,413	7,254	86%	8,747	7,519	86%
Superior HealthPlan	111,822	82,185	73%	118,431	86,119	73%
Texas Children's Health Plan	10,004	9,937	99%	10,605	10,540	99%
UnitedHealthcare Community Plan	6,373	6,289	99%	6,825	6,662	98%
<b>STAR Total</b>	<b>3,148,901</b>	<b>2,929,392</b>	93%	<b>3,323,122</b>	<b>3,071,220</b>	92%
<b>STAR+PLUS</b>						
Metro	175,958	172,922	98%	175,925	172,823	98%
Amerigroup	46,755	46,581	100%	46,683	46,505	100%
Cigna-HealthSpring	11,341	10,763	95%	11,355	10,775	95%
Molina Healthcare of Texas	29,839	29,726	100%	29,844	29,744	100%
Superior HealthPlan	46,437	44,313	95%	46,281	44,187	95%
UnitedHealthcare Community Plan	41,586	41,539	100%	41,762	41,612	100%
Micro	14,707	13,747	93%	14,710	13,750	93%

## Attachment H2

Specialist Network Access Analysis SFY21  
(Blanks = No Data Available)

Program County Type MCO	Quarter 1			Quarter 2		
	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)
Amerigroup	1,643	1,642	100%	1,629	1,628	100%
Cigna-HealthSpring	3,457	3,277	95%	3,433	3,265	95%
Molina Healthcare of Texas	600	485	81%	605	490	81%
Superior HealthPlan	2,825	2,241	79%	2,821	2,245	80%
UnitedHealthcare Community Plan	6,182	6,102	99%	6,222	6,122	98%
Rural	19,599	16,887	86%	19,652	17,042	87%
Amerigroup	3,489	3,091	89%	3,493	3,221	92%
Cigna-HealthSpring	1,618	1,508	93%	1,623	1,515	93%
Molina Healthcare of Texas	1,046	1,037	99%	1,024	1,016	99%
Superior HealthPlan	8,167	6,199	76%	8,182	6,185	76%
UnitedHealthcare Community Plan	5,279	5,052	96%	5,330	5,105	96%
<b>STAR+PLUS Total</b>	<b>210,264</b>	<b>203,556</b>	<b>97%</b>	<b>210,287</b>	<b>203,615</b>	<b>97%</b>
<b>STAR Kids</b>						
Metro	125,208	119,061	95%	127,622	121,282	95%
Aetna Better Health	4,444	4,444	100%	4,646	4,646	100%
Amerigroup	23,606	23,536	100%	24,409	24,318	100%
Blue Cross and Blue Shield of Texas	6,080	3,100	51%	6,213	3,151	51%
Community First Health Plans	6,812	6,774	99%	6,939	6,905	100%
Cook Children's Health Plan	8,979	8,834	98%	9,064	8,936	99%
Driscoll Health Plan	7,906	6,765	86%	8,006	6,836	85%
Superior HealthPlan	22,613	20,875	92%	23,006	21,248	92%
Texas Children's Health Plan	23,313	23,295	100%	23,666	23,649	100%
UnitedHealthcare Community Plan	21,455	21,438	100%	21,673	21,593	100%
Micro	8,119	6,887	85%	8,357	7,177	86%
Aetna Better Health	41	41	100%	43	43	100%
Amerigroup	270	270	100%	275	275	100%
Blue Cross and Blue Shield of Texas	620	311	50%	628	317	50%
Community First Health Plans	102	102	100%	107	107	100%
Cook Children's Health Plan	123	111	90%	121	121	100%
Driscoll Health Plan	488	412	84%	494	419	85%
Superior HealthPlan	1,461	977	67%	1,488	1,006	68%
Texas Children's Health Plan	2,201	1,980	90%	2,325	2,137	92%
UnitedHealthcare Community Plan	2,813	2,683	95%	2,876	2,752	96%
Rural	9,646	8,097	84%	9,861	8,301	84%
Amerigroup	1,816	1,584	87%	1,849	1,677	91%
Blue Cross and Blue Shield of Texas	857	610	71%	879	614	70%
Community First Health Plans	245	245	100%	241	241	100%
Driscoll Health Plan	779	754	97%	786	761	97%
Superior HealthPlan	2,301	1,482	64%	2,356	1,520	65%
Texas Children's Health Plan	1,299	1,287	99%	1,349	1,337	99%
UnitedHealthcare Community Plan	2,349	2,135	91%	2,401	2,151	90%
<b>STAR Kids Total</b>	<b>142,973</b>	<b>134,045</b>	<b>94%</b>	<b>145,840</b>	<b>136,760</b>	<b>94%</b>
<b>Psychiatrist Total</b>	<b>3,502,138</b>	<b>3,266,993</b>	<b>93%</b>	<b>3,679,249</b>	<b>3,411,595</b>	<b>93%</b>
<b>Therapies - Occupational, Physical, or Speech Therapy</b>						
<b>STAR</b>						
Metro	2,711,839	2,699,458	100%	2,859,156	2,846,071	100%
Aetna Better Health	76,748	76,730	100%	82,593	82,593	100%
Amerigroup	504,573	504,187	100%	534,681	534,351	100%
Blue Cross and Blue Shield of Texas	31,241	31,241	100%	33,560	33,560	100%
Community First Health Plans	109,084	109,084	100%	115,611	115,611	100%
Community Health Choice	261,022	261,022	100%	275,223	275,222	100%
Cook Children's Health Plan	112,170	111,904	100%	117,811	117,804	100%
Dell Children's Health Plan	24,247	24,247	100%	25,982	25,982	100%
Driscoll Health Plan	135,505	135,504	100%	142,172	142,169	100%
El Paso First	67,556	67,556	100%	71,157	71,157	100%
FirstCare	42,834	31,282	73%	45,191	32,590	72%
Molina Healthcare of Texas	89,048	89,028	100%	93,005	93,005	100%
Parkland	167,303	167,250	100%	176,125	176,068	100%
Right Care from Scott and White Health Plans	33,371	33,371	100%	34,961	34,961	100%
Superior HealthPlan	551,871	551,789	100%	577,239	577,157	100%
Texas Children's Health Plan	366,002	366,002	100%	384,774	384,773	100%
UnitedHealthcare Community Plan	139,264	139,261	100%	149,071	149,068	100%

## Attachment H2

Specialist Network Access Analysis SFY21  
(Blanks = No Data Available)

Program County Type MCO	Quarter 1			Quarter 2		
	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)
Micro	186,645	183,642	98%	199,296	196,075	98%
Aetna Better Health	1,241	1,241	100%	1,332	1,332	100%
Amerigroup	33,245	33,245	100%	35,736	35,736	100%
Blue Cross and Blue Shield of Texas	3,927	3,927	100%	4,363	4,363	100%
Community First Health Plans	2,129	2,129	100%	2,270	2,270	100%
Community Health Choice	7,858	7,858	100%	8,621	8,621	100%
Cook Children's Health Plan	3,041	3,041	100%	3,276	3,276	100%
Dell Children's Health Plan	2,333	2,333	100%	2,576	2,576	100%
Driscoll Health Plan	13,321	13,321	100%	14,050	14,050	100%
FirstCare	3,003	0	0%	3,152	0	0%
Molina Healthcare of Texas	2,799	2,799	100%	2,955	2,955	100%
Right Care from Scott and White Health Plans	3,612	3,612	100%	3,901	3,901	100%
Superior HealthPlan	88,467	88,467	100%	93,457	93,388	100%
Texas Children's Health Plan	11,219	11,219	100%	12,373	12,373	100%
UnitedHealthcare Community Plan	10,450	10,450	100%	11,234	11,234	100%
Rural	250,417	231,219	92%	264,670	239,810	91%
Aetna Better Health	1,051	1,051	100%	1,163	1,163	100%
Amerigroup	48,183	46,005	95%	51,279	48,915	95%
Blue Cross and Blue Shield of Texas	1,611	1,611	100%	1,713	1,713	100%
Community First Health Plans	5,181	5,181	100%	5,493	5,493	100%
Community Health Choice	8,655	8,628	100%	8,997	8,976	100%
Dell Children's Health Plan	707	707	100%	742	742	100%
Driscoll Health Plan	17,241	17,241	100%	18,014	18,014	100%
El Paso First	15	14	93%	16	15	94%
FirstCare	27,311	15,242	56%	28,619	15,906	56%
Molina Healthcare of Texas	3,191	3,170	99%	3,315	3,297	99%
Parkland	659	659	100%	711	711	100%
Right Care from Scott and White Health Plans	8,413	8,342	99%	8,747	8,673	99%
Superior HealthPlan	111,822	107,085	96%	118,431	108,880	92%
Texas Children's Health Plan	10,004	9,963	100%	10,605	10,563	100%
UnitedHealthcare Community Plan	6,373	6,320	99%	6,825	6,749	99%
<b>STAR Total</b>	<b>3,148,901</b>	<b>3,114,319</b>	<b>99%</b>	<b>3,323,122</b>	<b>3,281,956</b>	<b>99%</b>
<b>STAR+PLUS</b>						
Metro	175,958	175,901	100%	175,925	175,875	100%
Amerigroup	46,755	46,733	100%	46,683	46,659	100%
Cigna-HealthSpring	11,341	11,319	100%	11,355	11,335	100%
Molina Healthcare of Texas	29,839	29,828	100%	29,844	29,843	100%
Superior HealthPlan	46,437	46,437	100%	46,281	46,281	100%
UnitedHealthcare Community Plan	41,586	41,584	100%	41,762	41,757	100%
Micro	14,707	14,707	100%	14,710	14,710	100%
Amerigroup	1,643	1,643	100%	1,629	1,629	100%
Cigna-HealthSpring	3,457	3,457	100%	3,433	3,433	100%
Molina Healthcare of Texas	600	600	100%	605	605	100%
Superior HealthPlan	2,825	2,825	100%	2,821	2,821	100%
UnitedHealthcare Community Plan	6,182	6,182	100%	6,222	6,222	100%
Rural	19,599	19,005	97%	19,652	18,793	96%
Amerigroup	3,489	3,276	94%	3,493	3,300	94%
Cigna-HealthSpring	1,618	1,610	100%	1,623	1,614	99%
Molina Healthcare of Texas	1,046	1,040	99%	1,024	1,019	100%
Superior HealthPlan	8,167	7,827	96%	8,182	7,561	92%
UnitedHealthcare Community Plan	5,279	5,252	99%	5,330	5,299	99%
<b>STAR+PLUS Total</b>	<b>210,264</b>	<b>209,613</b>	<b>100%</b>	<b>210,287</b>	<b>209,378</b>	<b>100%</b>
<b>STAR Kids</b>						
Metro	125,208	125,180	100%	127,622	127,614	100%
Aetna Better Health	4,444	4,439	100%	4,646	4,646	100%
Amerigroup	23,606	23,606	100%	24,409	24,409	100%
Blue Cross and Blue Shield of Texas	6,080	6,080	100%	6,213	6,213	100%
Community First Health Plans	6,812	6,812	100%	6,939	6,939	100%
Cook Children's Health Plan	8,979	8,964	100%	9,064	9,064	100%
Driscoll Health Plan	7,906	7,906	100%	8,006	8,006	100%
Superior HealthPlan	22,613	22,613	100%	23,006	23,006	100%
Texas Children's Health Plan	23,313	23,306	100%	23,666	23,660	100%



## Attachment H2

Specialist Network Access Analysis SFY21  
(Blanks = No Data Available)

Program County Type MCO	Quarter 1			Quarter 2		
	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)
UnitedHealthcare Community Plan	21,455	21,454	100%	21,673	21,671	100%
Micro	8,119	8,119	100%	8,357	8,355	100%
Aetna Better Health	41	41	100%	43	43	100%
Amerigroup	270	270	100%	275	275	100%
Blue Cross and Blue Shield of Texas	620	620	100%	628	628	100%
Community First Health Plans	102	102	100%	107	107	100%
Cook Children's Health Plan	123	123	100%	121	121	100%
Driscoll Health Plan	488	488	100%	494	494	100%
Superior HealthPlan	1,461	1,461	100%	1,488	1,486	100%
Texas Children's Health Plan	2,201	2,201	100%	2,325	2,325	100%
UnitedHealthcare Community Plan	2,813	2,813	100%	2,876	2,876	100%
Rural	9,646	9,429	98%	9,861	9,447	96%
Amerigroup	1,816	1,705	94%	1,849	1,735	94%
Blue Cross and Blue Shield of Texas	857	857	100%	879	879	100%
Community First Health Plans	245	245	100%	241	241	100%
Driscoll Health Plan	779	779	100%	786	786	100%
Superior HealthPlan	2,301	2,212	96%	2,356	2,074	88%
Texas Children's Health Plan	1,299	1,289	99%	1,349	1,339	99%
UnitedHealthcare Community Plan	2,349	2,342	100%	2,401	2,393	100%
<b>STAR Kids Total</b>	<b>142,973</b>	<b>142,728</b>	<b>100%</b>	<b>145,840</b>	<b>145,416</b>	<b>100%</b>
<b>Therapies - OT PT ST Total</b>	<b>3,502,138</b>	<b>3,466,660</b>	<b>99%</b>	<b>3,679,249</b>	<b>3,636,750</b>	<b>99%</b>
<b>Urologist</b>						
<b>STAR</b>						
Metro	2,711,839	2,534,475	93%	2,859,156	2,704,696	95%
Aetna Better Health	76,748	75,731	99%	82,593	81,530	99%
Amerigroup	504,573	489,731	97%	534,681	519,161	97%
Blue Cross and Blue Shield of Texas	31,241	31,237	100%	33,560	33,555	100%
Community First Health Plans	109,084	109,084	100%	115,611	115,611	100%
Community Health Choice	261,022	249,656	96%	275,223	263,468	96%
Cook Children's Health Plan	112,170	62,803	56%	117,811	115,113	98%
Dell Children's Health Plan	24,247	23,724	98%	25,982	25,897	100%
Driscoll Health Plan	135,505	135,468	100%	142,172	142,135	100%
El Paso First	67,556	67,556	100%	71,157	71,157	100%
FirstCare	42,834	19,145	45%	45,191	20,662	46%
Molina Healthcare of Texas	89,048	86,084	97%	93,005	90,325	97%
Parkland	167,303	156,437	94%	176,125	164,741	94%
Right Care from Scott and White Health Plans	33,371	28,030	84%	34,961	29,244	84%
Superior HealthPlan	551,871	525,754	95%	577,239	529,504	92%
Texas Children's Health Plan	366,002	345,396	94%	384,774	364,825	95%
UnitedHealthcare Community Plan	139,264	128,639	92%	149,071	137,768	92%
Micro	186,645	155,592	83%	199,296	169,475	85%
Aetna Better Health	1,241	1,241	100%	1,332	1,332	100%
Amerigroup	33,245	30,558	92%	35,736	32,745	92%
Blue Cross and Blue Shield of Texas	3,927	3,927	100%	4,363	4,363	100%
Community First Health Plans	2,129	2,129	100%	2,270	2,270	100%
Community Health Choice	7,858	6,947	88%	8,621	7,682	89%
Cook Children's Health Plan	3,041	664	22%	3,276	2,910	89%
Dell Children's Health Plan	2,333	2,333	100%	2,576	2,576	100%
Driscoll Health Plan	13,321	10,870	82%	14,050	11,502	82%
FirstCare	3,003	0	0%	3,152	0	0%
Molina Healthcare of Texas	2,799	1,307	47%	2,955	1,404	48%
Right Care from Scott and White Health Plans	3,612	2,587	72%	3,901	2,796	72%
Superior HealthPlan	88,467	77,445	88%	93,457	81,883	88%
Texas Children's Health Plan	11,219	8,281	74%	12,373	9,969	81%
UnitedHealthcare Community Plan	10,450	7,303	70%	11,234	8,043	72%
Rural	250,417	180,262	72%	264,670	189,117	71%
Aetna Better Health	1,051	1,051	100%	1,163	1,163	100%
Amerigroup	48,183	36,734	76%	51,279	39,181	76%
Blue Cross and Blue Shield of Texas	1,611	1,467	91%	1,713	1,559	91%
Community First Health Plans	5,181	5,181	100%	5,493	5,493	100%
Community Health Choice	8,655	7,101	82%	8,997	7,375	82%
Dell Children's Health Plan	707	654	93%	742	688	93%



## Attachment H2

Specialist Network Access Analysis SFY21  
(Blanks = No Data Available)

Program County Type MCO	Quarter 1			Quarter 2		
	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)
Driscoll Health Plan	17,241	16,950	98%	18,014	17,719	98%
El Paso First	15	14	93%	16	15	94%
FirstCare	27,311	6,847	25%	28,619	7,195	25%
Molina Healthcare of Texas	3,191	2,978	93%	3,315	3,091	93%
Parkland	659	643	98%	711	690	97%
Right Care from Scott and White Health Plans	8,413	5,490	65%	8,747	5,679	65%
Superior HealthPlan	111,822	81,434	73%	118,431	84,688	72%
Texas Children's Health Plan	10,004	8,842	88%	10,605	9,360	88%
UnitedHealthcare Community Plan	6,373	4,876	77%	6,825	5,221	76%
<b>STAR Total</b>	<b>3,148,901</b>	<b>2,870,329</b>	<b>91%</b>	<b>3,323,122</b>	<b>3,063,288</b>	<b>92%</b>
<b>STAR+PLUS</b>						
Metro	175,958	167,257	95%	175,925	166,360	95%
Amerigroup	46,755	45,842	98%	46,683	45,845	98%
Cigna-HealthSpring	11,341	10,218	90%	11,355	10,229	90%
Molina Healthcare of Texas	29,839	27,894	93%	29,844	28,392	95%
Superior HealthPlan	46,437	44,883	97%	46,281	43,293	94%
UnitedHealthcare Community Plan	41,586	38,420	92%	41,762	38,601	92%
Micro	14,707	12,892	88%	14,710	12,932	88%
Amerigroup	1,643	1,549	94%	1,629	1,537	94%
Cigna-HealthSpring	3,457	2,957	86%	3,433	2,940	86%
Molina Healthcare of Texas	600	375	63%	605	387	64%
Superior HealthPlan	2,825	2,441	86%	2,821	2,436	86%
UnitedHealthcare Community Plan	6,182	5,570	90%	6,222	5,632	91%
Rural	19,599	14,971	76%	19,652	14,921	76%
Amerigroup	3,489	2,411	69%	3,493	2,423	69%
Cigna-HealthSpring	1,618	1,380	85%	1,623	1,385	85%
Molina Healthcare of Texas	1,046	965	92%	1,024	944	92%
Superior HealthPlan	8,167	6,032	74%	8,182	5,938	73%
UnitedHealthcare Community Plan	5,279	4,183	79%	5,330	4,231	79%
<b>STAR+PLUS Total</b>	<b>210,264</b>	<b>195,120</b>	<b>93%</b>	<b>210,287</b>	<b>194,213</b>	<b>92%</b>
<b>STAR Kids</b>						
Metro	125,208	114,323	91%	127,622	118,925	93%
Aetna Better Health	4,444	4,351	98%	4,646	4,554	98%
Amerigroup	23,606	22,658	96%	24,409	23,447	96%
Blue Cross and Blue Shield of Texas	6,080	6,075	100%	6,213	6,208	100%
Community First Health Plans	6,812	6,812	100%	6,939	6,939	100%
Cook Children's Health Plan	8,979	5,239	58%	9,064	8,922	98%
Driscoll Health Plan	7,906	7,904	100%	8,006	8,004	100%
Superior HealthPlan	22,613	21,379	95%	23,006	20,259	88%
Texas Children's Health Plan	23,313	21,215	91%	23,666	21,679	92%
UnitedHealthcare Community Plan	21,455	18,690	87%	21,673	18,913	87%
Micro	8,119	6,870	85%	8,357	7,205	86%
Aetna Better Health	41	41	100%	43	43	100%
Amerigroup	270	270	100%	275	275	100%
Blue Cross and Blue Shield of Texas	620	620	100%	628	628	100%
Community First Health Plans	102	102	100%	107	107	100%
Cook Children's Health Plan	123	38	31%	121	108	89%
Driscoll Health Plan	488	433	89%	494	439	89%
Superior HealthPlan	1,461	1,104	76%	1,488	1,123	75%
Texas Children's Health Plan	2,201	1,907	87%	2,325	2,065	89%
UnitedHealthcare Community Plan	2,813	2,355	84%	2,876	2,417	84%
Rural	9,646	7,201	75%	9,861	7,290	74%
Amerigroup	1,816	1,245	69%	1,849	1,260	68%
Blue Cross and Blue Shield of Texas	857	791	92%	879	797	91%
Community First Health Plans	245	245	100%	241	241	100%
Driscoll Health Plan	779	775	99%	786	783	100%
Superior HealthPlan	2,301	1,280	56%	2,356	1,254	53%
Texas Children's Health Plan	1,299	1,235	95%	1,349	1,283	95%
UnitedHealthcare Community Plan	2,349	1,630	69%	2,401	1,672	70%
<b>STAR Kids Total</b>	<b>142,973</b>	<b>128,394</b>	<b>90%</b>	<b>145,840</b>	<b>133,420</b>	<b>91%</b>
<b>Urologist Total</b>	<b>3,502,138</b>	<b>3,193,843</b>	<b>91%</b>	<b>3,679,249</b>	<b>3,390,921</b>	<b>92%</b>

**Main Dentist Network Access Analysis SFY21**  
**(Blanks = No Data Available)**

County Type DMO	Quarter 1			Quarter 2		
	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (95%)	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (95%)
<b>Metro</b>	<b>2,610,893</b>	<b>2,610,587</b>	100%	<b>2,734,672</b>	<b>2,734,340</b>	100%
DentaQuest	1,497,408	1,497,275	100%	1,551,543	1,551,399	100%
MCNA Dental	1,092,060	1,091,893	100%	1,102,738	1,102,563	100%
United HealthCare Dental	21,425	21,419	100%	80,391	80,378	100%
<b>Micro</b>	<b>178,318</b>	<b>178,267</b>	100%	<b>189,631</b>	<b>189,613</b>	100%
DentaQuest	104,011	104,009	100%	109,356	109,354	100%
MCNA Dental	72,905	72,903	100%	74,493	74,491	100%
United HealthCare Dental	1,402	1,355	97%	5,782	5,768	100%
<b>Rural</b>	<b>237,280</b>	<b>237,244</b>	100%	<b>249,348</b>	<b>249,289</b>	100%
DentaQuest	136,738	136,715	100%	142,459	142,432	100%
MCNA Dental	98,945	98,933	100%	99,814	99,798	100%
United HealthCare Dental	1,597	1,596	100%	7,075	7,059	100%
<b>Grand Total</b>	<b>3,026,491</b>	<b>3,026,098</b>	100%	<b>3,173,651</b>	<b>3,173,242</b>	100%

## Attachment H4

## Dental Specialty Network Access Analysis SFY21

(Blanks = No Data Available)

Provider Type DMO County Type	Quarter 1			Quarter 2		
	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)	Member Count	Members Within Distance Standard of Two Providers	% Within Distance Standard (90%)
<b>Orthodontist</b>						
DentaQuest	1,738,157	1,605,031	92%	2,734,672	2,632,810	96%
Metro	1,497,408	1,440,584	96%	1,551,543	1,493,803	96%
Micro	104,011	65,597	63%	1,102,738	1,066,512	97%
Rural	136,738	98,850	72%	80,391	72,495	90%
MCNA Dental	1,263,910	1,179,554	93%	189,631	122,077	64%
Metro	1,092,060	1,056,102	97%	109,356	69,360	63%
Micro	72,905	47,991	66%	74,493	49,231	66%
Rural	98,945	75,461	76%	5,782	3,486	60%
United HealthCare	24,424	21,417	88%	249,348	187,044	75%
Metro	21,425	19,545	91%	142,459	106,305	75%
Micro	1,402	815	58%	99,814	75,978	76%
Rural	1,597	1,057	66%	7,075	4,761	67%
<b>Subtotal</b>	<b>3,026,491</b>	<b>2,806,002</b>	<b>93%</b>	<b>3,173,651</b>	<b>2,941,931</b>	<b>93%</b>
<b>Pediatric Dental</b>						
DentaQuest	1,630,397	1,618,970	99%	2,542,790	1,442,318	57%
Metro	1,404,881	1,400,197	100%	1,441,491	1,436,632	100%
Micro	97,369	92,600	95%	1,026,671	0	0%
Rural	128,147	126,173	98%	74,628	5,686	8%
MCNA Dental	1,188,132	0	0%	176,172	97,173	55%
Metro	1,027,046	0	0%	101,510	96,552	95%
Micro	68,469	0	0%	69,310	0	0%
Rural	92,617	0	0%	5,352	621	12%
United HealthCare	24,424	1,658	7%	231,274	130,940	57%
Metro	21,425	1,359	6%	132,226	130,140	98%
Micro	1,402	115	8%	92,523	0	0%
Rural	1,597	184	12%	6,525	800	12%
<b>Subtotal</b>	<b>2,842,953</b>	<b>1,620,628</b>	<b>57%</b>	<b>2,950,236</b>	<b>1,670,431</b>	<b>57%</b>

## D-047 CMS NARRATIVE SUMMARY REPORT



Helping Government Serve the People.®



***September 2020 – November 2020***

## 1.1 MAIL SUMMARY

The Enrollment Broker Correspondence and Materials Development (CMD) unit continued its efforts throughout the reporting period to inform Managed Care recipients about their medical and dental enrollment options in Managed Care areas.

Table 1.1A details Medicaid Managed Care (MMC) Medical and Dental monthly mailing activities completed by CMD during the reporting period.

Monthly Ongoing Mailings					
Mail Type	Sep-20	Oct-20	Nov-20	Bi-Annual Totals	Average per Month
STAR	63,277	66,152	87,757	217,186	72,395
STAR Kids	1,212	1,279	1,084	3,575	1,192
STAR+PLUS	5,128	5,710	5,409	16,247	5,416
MMC Dental	54,770	57,494	78,665	190,929	63,643

*(Table 1.1A) Mail Summary: The table shows the total and average volumes mailed for the MMC Medical and Dental programs*

## 1.2 COMMUNITY OUTREACH SUMMARY

To mitigate the spread of COVID-19 and to protect the health and welfare of Texans, EB Outreach suspended face to face/in-person community and client outreach — including home visits, presentations, community contacts, and enrollment events — on March 17, 2020, until further notice. During this suspension, outreach will increase their phone call attempts to clients, make community contacts by phone, and attend meetings remotely when possible.

Maximus completes outbound outreach via telephone to Medicaid Managed Care clients. Table 1.2A summarizes overall outbound call attempts to MMC clients for the reporting period.

Outbound Call Activity – MMC					
Program	Sep-20	Oct-20	Nov-20	Bi-Annual Totals	Average per Month
Medicaid Managed Care Outbound Attempts	75,196	80,228	57,137	212,561	70,854

*(Table 1.2A) MMC Outbound Call Activity*

Throughout the reporting period, outreach staff members completed a total of 4,331 field events for the Medicaid Managed Care Program through conference call functionality. Field events include enrollment events, community meetings, presentations, and health fairs. Please note all activities were done remotely via virtual technology (Zoom or Microsoft Teams) due to the suspension of face-to-face activities to mitigate COVID-19.

Table 1.2B summarizes EB Outreach activities throughout the reporting period.

Community Outreach Activities – MMC					
Task	Sep-20	Oct-20	Nov-20	Bi-Annual Totals	Average per Month
MMC Home Visit Attempts	0	0	0	0	0
MMC Home Visit Requests	0	0	0	0	0
MMC Enrollment Events	0	0	0	0	0

MMC Presentations (non-enrollment event)	27	37	41	<b>105</b>	<b>35</b>
MMC Community Meetings (non-enrollment event)	1,328	1,618	1,278	<b>4,224</b>	<b>1,408</b>
MMC Health Fairs (non-enrollment event)	1	1	0	<b>2</b>	<b>1</b>

(Table 1.2B) MMC Community Outreach Activities

### 1.3 ENROLLMENTS SUMMARY

Tables 1.3A, 1.3B, and 1.3C give an overview of the enrollment activity in the Enrollment Broker Medicaid Managed Care and Dental Programs reported for October 1<sup>st</sup> through December 1<sup>st</sup> effective dates. The STAR, STAR+PLUS, and STAR Kids Programs reported an average of 4,186,340 total enrollments per month.

Total Enrollments by Program				
State Cutoff Month	STAR	STAR+PLUS	STAR Kids	Total Enrollments
Sep-20	3,420,464	538,025	167,265	<b>4,125,754</b>
Oct-20	3,475,295	537,363	168,420	<b>4,181,078</b>
Nov-20	3,545,067	537,781	169,341	<b>4,252,189</b>
<b>Average per Month</b>	<b>3,480,275</b>	<b>537,723</b>	<b>168,342</b>	<b>4,186,340</b>

(Table 1.3A) Total Enrollments by Program. Enrollment totals are reported from the monthly Confirmed Eligibles Report

Total New Monthly Enrollments by Program				
State Cutoff Month	STAR	STAR+PLUS	STAR Kids	Total New Monthly Enrollments
Sep-20	88,056	6,008	2,557	<b>96,621</b>
Oct-20	86,761	6,291	2,475	<b>95,527</b>
Nov-20	103,332	7,342	2,556	<b>113,230</b>
<b>Average per Month</b>	<b>92,716</b>	<b>6,547</b>	<b>2,529</b>	<b>101,793</b>

(Table 1.3B) Total New Monthly Enrollments by Program. Enrollment totals are reported from the monthly Confirmed Eligibles Report

The Dental Program reported an average of 3,314,187 total enrollments in the reporting period.

Dental Enrollments		
State Cutoff Month	New Monthly Enrollment	Total Enrollment
Sep-20	71,471	3,267,125
Oct-20	59,843	3,309,740
Nov-20	72,466	3,365,695

<b>Average per Month</b>	<b>67,927</b>	<b>3,314,187</b>
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(Table 1.3C) Dental Enrollments as reported from the monthly Confirmed Eligibles Report

## 1.4 CALL CENTER

Table 1.4A summarizes the performance of the Medicaid EB Call Center Inbound Queues – both English and Spanish combined – for the reporting period.

The AB rate for the reporting period was 2.3 percent, and the ASA was 44 seconds for the Medicaid EB Call Center Inbound Queues. The AB Rate and ASA performance standards were met for each month of the reporting period. The AHT for the reporting period was 637 seconds.

EB Call Center Inbound Production									
Month	Year	Forecast Calls	Calls Offered	Calls Handled	Sys Out Calls	Average Handle Time	Average Speed of Answer	Abandon	% Abandon
September	2020	82,366	83,232	79,214	1,779	635	47	2,225	2.7%
October	2020	90,750	82,829	82,008	349	620	10	468	0.6%
November	2020	67,230	76,289	72,309	1,100	659	80	2,877	3.8%
AVG		<b>80,115</b>	<b>80,783</b>	<b>77,844</b>	<b>1,076</b>	<b>637</b>	<b>44</b>	<b>1,857</b>	<b>2.3%</b>
Totals		<b>240,346</b>	<b>242,350</b>	<b>233,531</b>	<b>3,228</b>			<b>5,570</b>	
KPR							<b>&lt; 140</b>		<b>≤ 10%</b>

(Table 1.4A) EB Call Center Inbound Production

## Attachment O

## Complaints to HHSC SFY21

## Q1

(Blanks = No Data Available)

Program/MCO	OMCAT Member Complaints	MCCO Legislative Complaints	MCCO Member Complaints	MCCO Provider Complaints
<b>Dental</b>				
DentaQuest	34		1	16
MCNA	17			5
United Healthcare Dental	2			
<b>Dental Total</b>	<b>53</b>	<b>0</b>	<b>1</b>	<b>21</b>
<b>STAR</b>				
Aetna	17			25
Amerigroup Texas, Inc.	66			61
Blue Cross and Blue Shield	12			1
Community First Health Plans	11			8
Community Health Choice	25		1	14
Cook Children's Health Plan	11		1	11
Dell's Children	6			4
Driscoll Health Plan	13	1		11
El Paso Health	4			2
Firstcare	5			16
Molina Healthcare of Texas	18		1	29
Parkland Community Health Plan	11			16
Scott and White	10			4
Superior HealthPlan	74	1		28
Texas Children's Health Plan	43			15
UHC Community Plan of Texas	20		1	18
<b>STAR Total</b>	<b>346</b>	<b>2</b>	<b>4</b>	<b>263</b>
<b>STAR+PLUS</b>				
Amerigroup Texas, Inc.	74		2	35
Cigna-HealthSpring	29	1	1	20
Molina Healthcare of Texas	68	1		104
Superior HealthPlan	121	1	1	37
UHC Community Plan of Texas	98	1		48
<b>STAR+PLUS Total</b>	<b>390</b>	<b>4</b>	<b>4</b>	<b>244</b>
<b>STAR Kids</b>				
Aetna	15			12
Amerigroup Texas, Inc.	12		7	7
Blue Cross and Blue Shield	3		10	5
Children's Medical Center	1			3
Community First Health Plans	4		12	9
Cook Children's Health Plan	7		4	2
Driscoll Health Plan	1		5	
Superior HealthPlan	18		1	7
Texas Children's Health Plan	26		11	9
UHC Community Plan of Texas	15		4	9
<b>STAR Kids Total</b>	<b>102</b>	<b>0</b>	<b>54</b>	<b>63</b>
<b>Grand Total</b>	<b>891</b>	<b>6</b>	<b>63</b>	<b>591</b>



## Attachment O

## Complaints to HHSC SFY21

## Q2

(Blanks = No Data Available)

Program/MCO	OMCAT Member Complaints	MCCO Legislative Complaints	MCCO Member Complaints	MCCO Provider Complaints
<b>Dental</b>				
DentaQuest	13		1	19
MCNA	14			1
United Healthcare Dental	1			1
<b>Dental Total</b>	<b>28</b>	<b>0</b>	<b>1</b>	<b>21</b>
<b>STAR</b>				
Aetna	16			25
Amerigroup Texas, Inc.	50	2	1	25
Blue Cross and Blue Shield	7			5
Community First Health Plans	7			5
Community Health Choice	25			8
Cook Children's Health Plan	22		1	10
Dell's Children	9			4
Driscoll Health Plan	10			11
El Paso Health	9			4
Firstcare	14			8
Molina Healthcare of Texas	19			16
Parkland Community Health Plan	22		1	22
Scott and White	6			2
Superior HealthPlan	80	1	1	40
Texas Children's Health Plan	34		1	8
UHC Community Plan of Texas	27			18
<b>STAR Total</b>	<b>357</b>	<b>3</b>	<b>5</b>	<b>211</b>
<b>STAR+PLUS</b>				
Amerigroup Texas, Inc.	71	2	5	49
Cigna-HealthSpring	31	1	3	12
Molina Healthcare of Texas	61	1	2	49
Superior HealthPlan	117	1	6	29
UHC Community Plan of Texas	79	1	1	35
<b>STAR+PLUS Total</b>	<b>359</b>	<b>6</b>	<b>17</b>	<b>174</b>
<b>STAR Kids</b>				
Aetna	20			14
Amerigroup Texas, Inc.	10			9
Blue Cross and Blue Shield	10	1	1	3
Children's Medical Center				3
Community First Health Plans	4			2
Cook Children's Health Plan	4			2
Driscoll Health Plan	4			2
Superior HealthPlan	15		1	8
Texas Children's Health Plan	22			1
UHC Community Plan of Texas	11			15
<b>STAR Kids Total</b>	<b>100</b>	<b>1</b>	<b>2</b>	<b>59</b>
<b>Grand Total</b>	<b>844</b>	<b>10</b>	<b>25</b>	<b>465</b>

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1148 (CMS-10398 #56)**. The time required to complete this information collection is estimated to average **7.5 hours** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Budget neutrality is a Federal policy that governs the Federal expenditures for 1115 demonstrations. It is assured by placing an upper limit on the amount of Federal Financial Participation (FFP) the state can receive during the demonstration. The upper limit represents what the state could have received in the absence of the 1115 demonstration.

The Budget Neutrality workbook will assist in collecting standardized data in order to determine financial performance for the demonstration in terms of budget neutrality.

The workbook has two major groups of tabs: the first group collects and calculates Without Waiver (WOW) numbers, and the second group calculates With Waiver (WW) numbers. Data is collected per each demonstration Medicaid Eligibility Group (MEG), by demonstration year (DY). A Medicaid section 1115 demonstration is considered budget neutral if the Federal title XIX match, or funding received by the state (i.e., "with waiver" expenditures) do not exceed what the state would have (or could have) received without the demonstration (i.e., "without waiver" expenditures). The workbook provides the ability to evaluate any variance between WW and WOW calculations.

The workbook consists of 15 tabs which contain different types of data and calculations. The following color schema is applied to the tabs:

Blue	Information populated in the Budget Neutrality workbook template based on the demonstration's approved STC
Red	Information populated by states on a quarterly basis or per the reporting requirements defined in the STC
Green	Information automatically populated based on the input from other worksheets

Note: Overview and Dropdowns tabs are read-only, no data entry is required. The Dropdowns tab displays the values used to build the dropdowns menus throughout the workbook, including the list of active waivers for the demonstration.

**Data Entry** Within the tabs where a State User populates information (C Report, Total Adjustments, WW Spending Projected, MemMon Actual, MemMon Projected, and Summary TC tabs), yellow highlighted cells denote where data entry may be needed (depending on DY being updated).

**Pre-populated values in the downloaded Budget Neutrality workbook template**

The original workbook entries are based on the STCs and other demonstration approval documentation. These entries are made on the DY Def, MEG Def, WOW PMPM & Agg, Program Spending Limits, and Summary TC tab (Phase-Down Percentage and Cumulative Target Percentage fields).

The MEG Def tab defines MEGs as Medicaid populations (core demonstration populations), Hypothetical populations (when a demonstration has separate budget neutrality agreements) and Tracking Only populations (for example, "pass-through" populations). The MEG Def tab also defines how expenditure numbers are calculated for a MEG (Per Capita vs. Aggregate) and the applicable scenarios (WOW, WW, or both). Also, the tab contains indicators defining MEG characteristics such as expenditure caps or applicability of savings phase-down calculations.

**Calculating With Waiver (WW) numbers**

**Demonstration Years Definitions**

DY	1	2	3	4	5	6	7	8	9	10	11
Start Date	10/1/2011	10/1/2012	10/1/2013	10/1/2014	10/1/2015	10/1/2016	10/1/2017	10/1/2018	10/1/2019	10/1/2020	10/1/2021
End Date	9/30/2012	10/2/2012	9/30/2014	9/30/2015	9/30/2016	9/30/2017	9/30/2018	9/30/2019	9/30/2020	9/30/2021	9/30/2022

Enter any general comments / notes:

## MEG Definitions

MEG Name	MEG Description	Savings Phase-Down	Expenditures Subject to Cap?	Hypothetical Populations Included in Calculations?	Start DY	Start Date	End DY	End Date
<b><u>Medicaid Per Capita</u></b>								
1	AMR Medicaid service expenditures for all participating individuals who are aged, or who are disabled and have Medicare	Savings Phase-Down	No	N/A	1	10/1/2011	11	9/30/2022
2	Disabled Medicare service expenditures for all participating individuals who are disabled and do not have Medicare	Savings Phase-Down	No	N/A	1	10/1/2011	11	9/30/2022
3	Adults Medicaid service expenditures for all participating individuals whose MEG is defined as Adults;	Savings Phase-Down	No	N/A	1	10/1/2011	11	9/30/2022
4	Children Medicaid service expenditures for all participating individuals whose MEG is defined as Children;	Savings Phase-Down	No	N/A	1	10/1/2011	11	9/30/2022
<b><u>Medicaid Per Capita - WOW only</u></b>								
		N/A	No	N/A				
		N/A	No	N/A				
		N/A	No	N/A				
		N/A		N/A				
<b><u>Medicaid Aggregate</u></b>								
		N/A		N/A				
		N/A		N/A				
		N/A		N/A				
		N/A		N/A				
<b><u>Medicaid Aggregate - WOW only</u></b>								
1	UPL for Excluded Population	N/A		N/A	7	10/1/2017	11	9/30/2022
2	UPL for Included Population	N/A		N/A	1	10/1/2011	11	9/30/2022
3	Physician UPL	N/A		N/A	1	10/1/2011	11	9/30/2022
4	Outpatient UPL	N/A		N/A	1	10/1/2011	11	9/30/2022
<b><u>Medicaid Aggregate - WW only</u></b>								
1	UC Pool	N/A		N/A				
2	DSRIP Pool	N/A		N/A	1	10/1/2011	11	9/30/2022
	Individuals who have no source of third party coverage, for services provided by hospitals or other selected providers	N/A		N/A	1	10/1/2011	11	9/30/2022
	All DSRIP Pool expenditures	N/A		N/A	1	10/1/2011	11	9/30/2022
		N/A		N/A				
<b><u>Hypothetical 1 Per Capita</u></b>								
		N/A		<u>Hypothetical Test 1</u>				
		N/A						
		N/A						
<b><u>Hypothetical 1 Aggregate</u></b>								
		N/A						
		N/A						
<b><u>Hypothetical 2 Per Capita</u></b>								
		N/A		<u>Hypothetical Test 2</u>				
		N/A						
		N/A						
<b><u>Hypothetical 2 Aggregate</u></b>								
		N/A						
		N/A						

N/A  
N/A  
N/A

Tracking Only

**WOW PMPMs and Aggregates**

		7	8	9	10	11
<b>Medicaid Per Capita</b> <i>AMR</i> <i>Disabled</i> <i>Adults</i> <i>Children</i>	1	\$1,253.57	\$1,301.21	\$1,350.66	\$1,401.98	\$1,455.26
	2	\$1,723.19	\$1,793.84	\$1,867.39	\$1,943.96	\$2,023.66
	3	\$1,023.19	\$1,077.42	\$1,134.52	\$1,194.65	\$1,257.96
	4	\$347.08	\$362.70	\$379.02	\$396.07	\$413.90
<b>Medicaid Aggregate - WOW only</b> <i>UPL for Excluded Population</i> <i>UPL for Included Population</i> <i>Physician UPL</i> <i>Outpatient UPL</i>	1	\$1,681,649,843	\$1,681,649,843	\$1,681,649,843	\$1,681,649,843	\$1,681,649,843
	2	\$2,346,880,705	\$2,346,880,705	\$2,346,880,705	\$2,346,880,705	\$2,346,880,705
	3	\$84,237,473	\$84,237,473	\$84,237,473	\$84,237,473	\$84,237,473
	4	\$72,483,206	\$72,483,206	\$72,483,206	\$72,483,206	\$72,483,206

## Program Spending Limits

					TOTAL
Program Name and Associated MEGs	7	8	9	10	11
Spending Cap					
UC Pool	\$3,101,776,278	\$3,101,776,278	\$2,346,880,705	\$2,346,880,705	\$ 33,926,194,671
Expenditures Subject to Cap					
UC Pool	\$3,095,960,912	\$2,956,422,900	\$3,701,879,805	\$1,480,546,548	
Variance	\$5,815,366	\$145,353,378	(\$1,354,999,100)	\$866,334,157	\$ 2,214,763,352
Over or Under			Over		

					TOTAL
Program Name and Associated MEGs	7	8	9	10	11
Spending Cap					
DSRIP Pool	\$3,100,000,000	\$3,100,000,000	\$2,910,000,000	\$2,490,000,000	\$ 26,118,000,000
Expenditures Subject to Cap					
DSRIP Pool	\$2,993,563,179	\$2,746,446,646	\$726,154,442		
Variance	\$106,436,821	\$353,553,354	\$2,183,845,558	\$2,490,000,000	\$ 6,309,123,799
Over or Under					

Reporting DV	10
Reporting Quarantee	2

Data Pulled On:	5/5/2021
For the Time	
Period Through:	3/3/2021

Paste all information related to the demonstration from Schedule C of the CMS 64 Waiver Expenditure Report.

1. On the Schedule C report, locate rows relevant to all expenditures for a specific demonstration.
2. Complete two copies of copyable starting from the cell in column A (Waiver Name).
  - MAP Waivers/ Federal Share section – info cell A100
  - MAP Waivers/ Federal Share section – info cell A200
3. If ADM waivers are applicable to the demonstration, complete two more rounds of copyable starting from the cell in column A (Waiver Name).
  - ADM Waivers/ Total Computable section – cell A300
  - ADM Waivers/ Federal Share section – cell A400

MAP WAIVERS[illegible]Federal Share[illegible]ADM Waivers[illegible]



## C Report Grouper

MAP Waivers Only

Total Computable										
MEG Names		C Report Waiver Names								
<u>Medicaid Per Capita</u>										
AMR	1	THQTIP-AMR	\$4,731,720,889	\$5,166,813,887	\$5,531,446,528	\$2,954,264,128				
Disabled	2	THQTIP-Disabled	\$8,292,569,566	\$9,078,024,007	\$9,427,089,439	\$4,975,575,811				
Adults	3	THQTIP-Adults	\$2,268,910,396	\$2,496,025,855	\$2,836,929,431	\$2,186,944,282				
Children	4	THQTIP-Children	\$8,160,455,897	\$8,451,970,523	\$9,008,377,165	\$5,448,406,189				
Children	4	THQTIP-M-CHIP	\$554							
Children	4	64.21U & 64.21UP THQTIP-Qualified	\$80							
<u>Medicaid Aggregate - WW only</u>										
UC Pool	1	THQTIP-UC	\$3,095,960,912	\$2,956,422,900	\$3,701,879,805	\$1,480,546,548				
UC Pool	1	THQTIP-UC UPL								
DSRIP Pool	2	THQTIP-DSRIP	\$2,993,563,179	\$2,746,446,646	\$726,154,442					
<b>TOTAL</b>			\$ 29,543,181,073	\$ 30,895,703,818	\$ 31,231,876,810	\$ 17,045,736,958	\$			-

**Adjustments made to the reported expenditures**

Enter total adjustments made to the expenditure numbers, including adjustments to the previous reporting periods.

Positive adjustments increase expenditures, and negative adjustments decrease expenditures.

Enter adjustments for every MEG for which adjustments were made or are planned.

**Helpful Hint:** Remember to enter total adjustments as positive or negative (for example, -\$10,000 reflects a decrease in expenditures).

		7	8	9	10	11	Description (type of collection, time period, CMS-64 reporting line, etc.)
<u>Medicaid Per Capita</u>	1						
	2						ACA HIPF
	3						ACA HIPF
	4						ACA HIPF
<u>Medicaid Aggregate - WW only</u>	1						
	2						
<u>UC Pool</u>							
<u>DSRIP Pool</u>							

## WW Spending - Actual

Total Computable

		7	8	9	10	11
<u>Medicaid Per Capita</u>						
1	AMR	\$4,731,720,689	\$5,164,888,021	\$5,531,446,528	\$2,954,264,128	
2	Disabled	\$8,292,569,566	\$8,959,086,025	\$9,427,089,439	\$4,975,575,811	
3	Adults	\$2,268,910,396	\$2,465,667,879	\$2,836,929,431	\$2,186,944,282	
4	Children	\$8,160,456,331	\$8,346,333,244	\$9,008,377,165	\$5,448,406,189	
<u>Medicaid Aggregate - WW only</u>						
1	UC Pool	\$3,095,960,912	\$2,956,422,900	\$3,701,879,805	\$1,480,546,548	
2	DSRIP Pool	\$2,993,563,179	\$2,746,446,646	\$726,154,442		
	<b>TOTAL</b>	<b>\$ 29,543,181,073</b>	<b>\$ 30,638,844,715</b>	<b>\$ 31,231,876,810</b>	<b>\$ 17,045,736,958</b>	<b>\$ -</b>

**WW Spending - Projected**

Enter projected spending for the demonstration which includes the remaining quarters of the current DY and all future DYs.

Enter the projected annual expenditures for each DY per MEG for the active DYs.

For the current DY, only future quarters should have projected spending information. Do not include expenditures that were reported as actuals.

<b>Total Computable</b>		7	8	9	10	11
<b><u>Medicaid Per Capita</u></b>						
AMR	1				\$2,744,233,102	\$ 6,196,586,170
Disabled	2				\$4,916,019,081	\$ 11,028,101,236
Adults	3				\$1,818,612,275	\$ 3,150,840,046
Children	4				\$4,637,687,127	\$ 10,206,965,140
<b><u>Medicaid Aggregate - WW only</u></b>						
UC Pool	1				\$2,392,659,645	\$ 3,873,206,193
DSRIP Pool	2				\$2,490,000,000	\$ -

BNIOK

**WW Spending - Total****Total Computable**

		7	8	9	10	11
<b><u>Medicaid Per Capita</u></b>						
AMR	1	\$4,731,720,689	\$5,164,888,021	\$5,531,446,528	\$5,698,497,230	\$6,196,586,170
Disabled	2	\$8,292,569,566	\$8,959,086,025	\$9,427,089,439	\$9,891,594,892	\$11,028,101,236
Adults	3	\$2,268,910,396	\$2,465,667,879	\$2,836,929,431	\$4,005,556,557	\$3,150,840,046
<b><u>Medicaid Aggregate - WW only</u></b>						
UC Pool	1	\$3,095,960,912	\$2,956,422,900	\$3,701,879,805	\$3,873,206,193	\$3,873,206,193
DSRIP Pool	2	\$2,993,563,179	\$2,746,446,646	\$726,154,442	\$2,490,000,000	
<b>TOTAL</b>		<b>\$ 29,543,181,073</b>	<b>\$ 30,638,844,715</b>	<b>\$ 31,231,876,810</b>	<b>\$ 36,044,948,188</b>	<b>\$ 34,455,698,786</b>

**Member Months - Actual**

Enter actual member months (number of beneficiaries times the number of enrolled months) for quarters to date for each active DY.

For the reported quarter, add the actual number of member months per each MEG to the previous actual number. The number should equal the total of ALL actual

**Note:** Depending of the specifics of the state, you can use Total member months or Average monthly unduplicated counts. Whichever definition is used, it must be

**Helpful Hint:** When updating a DY, remember to enter actual member months for the reported quarter along with actuals for prior quarter(s). Retroactive adjustment

		7	8	9	10	11
<b><u>Medicaid Per Capita</u></b>						
AMR	1	4,269,502	4,253,307	4,275,480	2,110,003	
Disabled	2	4,990,565	4,898,960	4,884,022	2,498,052	
Adults	3	3,416,904	3,275,131	3,613,597	2,566,337	
Children	4	31,614,307	30,691,208	31,808,171	17,971,892	

applied consistently.  
ants may affect the entries.

## Member Months - Projected

Enter/adjust projected member months based on reported actuals.

Enter projected number of member months for each active DY per MEG for the demonstration.

For the current DY, enter only the number that reflects projections for future quarters of the DY.

Do not include member months for either the current reporting quarter or past quarters.

	7	8	9	10	11
<b><u>Medicaid Per Capita</u></b>					
AMR	1			2120913	4,348,666
Disabled	2			2547470	5,151,745
Adults	3			3101639	3,366,107
Children	4			19447085	32,945,528



**Member Months - Total**

		7	8	9	10	11
<b><u>Medicaid Per Capita</u></b>						
AMR	1	4,269,502	4,253,307	4,275,480	4,230,916	4,348,666
Disabled	2	4,990,565	4,898,960	4,884,022	5,045,223	5,151,745
Adults	3	3,416,904	3,275,131	3,613,597	5,667,977	3,366,107
Children	4	31,614,307	30,691,208	31,808,171	37,418,977	32,945,528

**Budget Neutrality Summary**

The Budget Neutrality Reporting Period dropdown menu allows for selection of a specific reporting period, by Demonstration Year. By changing these settings, you change the view for which Demonstration Years will be used in calculating Budget Neutrality. Selecting the 'Reset to Defaults' button will reset the Reporting DY values back to the demonstration's current Period of Performance.

Budget Neutrality Reporting Start DY	7
Budget Neutrality Reporting End DY	11

Actuals + Projected
---------------------

<u>Without-Waiver Total Expenditures</u>		7	8	9	10	11	Total
<u>Medicaid Per Capita</u>	1	Total PMPM	\$ 5,352,119,104	\$ 5,534,445,481	\$ 5,774,720,248	\$ 5,931,659,842	\$ 6,328,440,069
		AMR	\$ 1,253,57	\$ 1,301,21	\$ 1,350,66	\$ 1,401,98	\$ 1,455,26
		Mem-Mon	\$ 4,269,502	\$ 4,253,307	\$ 4,275,480	\$ 4,230,916	\$ 4,348,666
	2	Total PMPM	\$ 8,599,691,481	\$ 8,787,950,011	\$ 9,120,374,109	\$ 9,807,710,934	\$ 10,425,379,628
<u>Adults</u>	3	Total PMPM	\$ 1,723,19	\$ 1,793,84	\$ 1,867,39	\$ 1,943,96	\$ 2,023,66
		Mem-Mon	\$ 4,990,565	\$ 4,898,960	\$ 4,884,022	\$ 5,045,223	\$ 5,151,745
		Total PMPM	\$ 3,496,142,004	\$ 3,528,691,642	\$ 4,099,698,460	\$ 6,771,248,220	\$ 4,234,428,578
		Mem-Mon	\$ 1,023,19	\$ 1,077,42	\$ 1,134,52	\$ 1,194,65	\$ 1,257,96
<u>Children</u>	4	Total PMPM	\$ 10,972,693,674	\$ 11,131,701,142	\$ 12,055,933,064	\$ 14,820,534,341	\$ 13,636,154,133
		Mem-Mon	\$ 347,08	\$ 362,70	\$ 379,02	\$ 396,07	\$ 413,90
		Total PMPM	\$ 31,614,307	\$ 30,691,208	\$ 31,806,171	\$ 37,418,977	\$ 32,945,528
		Mem-Mon					
<u>Medicaid Aggregate - WOW only</u>	1	Total	\$ 1,681,649,843	\$ 1,681,649,843	\$ 1,681,649,843	\$ 1,681,649,843	\$ 1,681,649,843
	2	Total	\$ 2,346,880,705	\$ 2,346,880,705	\$ 2,346,880,705	\$ 2,346,880,705	\$ 2,346,880,705
	3	Total	\$ 84,237,473	\$ 84,237,473	\$ 84,237,473	\$ 84,237,473	\$ 84,237,473
	4	Total	\$ 72,483,206	\$ 72,483,206	\$ 72,483,206	\$ 72,483,206	\$ 72,483,206
<b>TOTAL</b>			<b>\$ 32,605,897,489</b>	<b>\$ 33,168,039,602</b>	<b>\$ 35,235,977,108</b>	<b>\$ 41,516,404,564</b>	<b>\$ 38,809,653,634</b>
							<b>\$ 181,335,972,298</b>

<u>With-Waiver Total Expenditures</u>		7	8	9	10	11	TOTAL
<u>Medicaid Per Capita</u>	1	AMR	\$ 4,731,720,689	\$ 5,164,888,021	\$ 5,531,446,528	\$ 5,698,497,230	\$ 6,196,586,170
	2	Disabled	\$ 8,292,569,566	\$ 8,959,086,025	\$ 9,427,089,439	\$ 9,891,594,892	\$ 11,028,101,236
	3	Adults	\$ 2,268,910,396	\$ 2,465,667,879	\$ 2,836,929,431	\$ 4,005,556,557	\$ 3,150,840,046
	4	Children	\$ 8,160,456,331	\$ 8,346,333,244	\$ 9,008,377,165	\$ 10,086,093,316	\$ 10,206,965,140
<u>Medicaid Aggregate - WW only</u>	1	UC Pool	\$ 3,095,960,912	\$ 2,956,422,900	\$ 3,701,879,805	\$ 3,873,206,193	\$ -
	2	DSRIP Pool	\$ 2,993,563,179	\$ 2,746,446,646	\$ 726,154,442	\$ 2,490,000,000	\$ -
<b>TOTAL</b>			<b>\$ 29,543,161,073</b>	<b>\$ 30,638,844,715</b>	<b>\$ 31,231,876,810</b>	<b>\$ 36,044,948,188</b>	<b>\$ 34,455,698,786</b>
							<b>\$ 161,914,549,571</b>

<u>Savings Phase-Down</u>		7	8	9	10	11	TOTAL
<u>Medicaid Per Capita</u>	1	<i>Savings Phase-Down</i> Without Waiver	\$ 5,352,119,104	\$ 5,534,445,481	\$ 5,774,720,248	\$ 5,931,659,842	\$ 6,328,440,069
		With Waiver	\$ 4,731,720,689	\$ 5,164,888,021	\$ 5,531,446,528	\$ 5,698,497,230	\$ 6,196,586,170
		Difference	\$ 620,398,415	\$ 369,557,459	\$ 243,273,720	\$ 233,162,612	\$ 131,853,899
		Phase-Down Percentage	86%	83%	76%	68%	60%
<u>Savings Reduction</u>			\$ 86,855,778	\$ 62,824,768	\$ 58,385,693	\$ 74,612,036	\$ 52,741,559
	2	<i>Savings Phase-Down</i> Without Waiver	\$ 8,599,691,481	\$ 8,787,950,011	\$ 9,120,374,109	\$ 9,807,710,934	\$ 10,425,379,628

[illegible][illegible]

Cumulative Target Limit			7	8	9	10	11
Cumulative Target Percentage (CTP)							
Cumulative Budget Neutrality Limit (CBNL)			\$ 30,749,793,658 \$	62,048,820,481 \$	94,965,007,732 \$	132,076,410,794 \$	168,024,564,918 \$
Allowed Cumulative Variance (= CTP X CBNL)			\$ 922,493,810 \$	\$ 620,488,205 \$	\$ 474,825,039 \$	- \$	- \$
(Actual Cumulative Variance - Positive = Overspending) and Co-spend Active Blows needed?			\$ (1,206,612,585) \$	(1,866,794,693) \$	(3,551,105,134) \$	(4,617,560,009) \$	(6,110,015,347) \$

7  
11

Demonstration Reporting Start DY  
Demonstration Reporting End DY

Waiver List  
MAP WAIVERS

Not Applicable  
64.21U & 64.21UP THTQIP-Qualified  
THTQIP 217-like AMR  
THTQIP 217-like Disabled  
THTQIP-Adults  
THTQIP-AMR  
THTQIP-Children  
THTQIP-Disabled  
THTQIP-DSRIP  
THTQIP-M-CHIP  
THTQIP-UC  
THTQIP-UC UPL

ADM WAIVERS

Yes No  
Yes  
No

Per Capita or Aggregate

Per Capita  
Aggregate

Phase-Down

No Phase-Down  
Savings Phase-Down

Actuals and Projected

Actuals Only  
Actuals + Projected

MAP ADM

MAP+ADM Waivers  
MAP Waivers Only

Reporting Net Variance  
\$ 5,960,645,349

Attachment Q  
Members with Special Health Care Needs SFY21  
(Blanks = No Data Available)

SDA	MCO	STAR										Q2						
		Q1					Q2											
		Total MSHCN	MSHCN with Service Plan	MSHCN without Service Plan*	Declined Service Management**	Unable to Reach**	Total MSHCN	MSHCN with Service Plan	MSHCN without Service Plan*	Declined Service Management**	Unable to Reach**							
Bexar	Aetha	41	23	56.10%	18	43.90%	14	77.78%	27	15	55.56%	12	44.44%	3	25.00%	9	75.00%	
	Amerigroup	1,123	76	6.77%	1,047	93.23%	152	14.52%	1,169	62	5.30%	1,107	94.70%	170	15.36%	937	84.64%	
	Community First Superior	513	163	31.77%	350	68.23%	31	8.86%	528	180	34.09%	348	65.91%	32	9.20%	316	90.80%	
	SDA Total	1,738	465	26.75%	1,273	73.25%	704	55.30%	1,496	300	20.09%	1,196	80.50%	502	33.56%	994	66.44%	
	SDA Total	3,415	727	21.29%	2,688	78.71%	891	26.09%	3,520	557	15.82%	2,963	84.18%	707	20.09%	2,256	64.09%	
Dallas	Amerigroup	12,530	1,671	13.34%	10,859	86.66%	1,924	17.72%	12,530	1,632	13.03%	11,533	87.60%	2,286	19.82%	9,247	80.18%	
	Molina	1,113	108	9.70%	1,005	90.30%	95	9.45%	1,132	151	13.34%	981	86.66%	106	10.81%	476	48.52%	
	Parkland	741	531	71.66%	210	28.34%	3	1.43%	741	330	73.83%	117	26.17%	1	0.85%	116	99.15%	
	SDA Total	14,384	2,310	16.06%	12,074	83.94%	2,022	14.06%	14,744	2,113	14.33%	12,631	85.67%	2,393	16.23%	9,839	66.73%	
	El Paso First	547	147	26.87%	400	73.13%	46	4.60%	599	157	26.21%	442	73.79%	48	10.85%	394	85.14%	
El Paso	Molina	100	13	13.00%	87	87.00%	4	4.00%	102	13	12.75%	89	87.25%	4	4.49%	54	60.67%	
	Superior	696	184	26.44%	512	73.56%	300	58.59%	661	84	12.71%	577	87.29%	217	37.61%	360	62.39%	
	SDA Total	1,343	344	25.61%	999	74.39%	350	26.06%	1,362	254	18.65%	1,108	81.35%	269	19.75%	808	59.32%	
	Amerigroup	4,322	524	12.12%	3,798	87.88%	709	18.67%	4,439	529	11.92%	3,910	88.08%	782	20.00%	3,128	80.00%	
	CHC	1,435	835	58.19%	600	41.81%	143	23.83%	1,533	943	61.51%	590	38.49%	137	23.22%	453	76.78%	
Harris	Molina	628	53	8.44%	575	91.56%	43	7.48%	637	86	13.50%	551	86.50%	53	9.62%	238	43.19%	
	Texas Children's	18,376	1,889	10.3%	16,487	89.7%	5,692	34.11%	19,914	1,618	8.12%	18,296	91.88%	5,589	30.55%	9,388	51.31%	
	United	1,301	1,141	87.70%	160	12.30%	24	1.84%	1,285	1,112	86.54%	173	13.46%	23	1.80%	150	86.71%	
	SDA Total	26,062	4,242	16.28%	21,820	83.72%	6,611	25.37%	27,808	4,288	15.42%	23,520	84.58%	6,584	23.68%	13,357	48.03%	
	Driscoll Children's	3,679	2,158	58.66%	1,521	41.34%	76	5.00%	3,171	2,069	65.25%	1,102	34.75%	56	5.08%	1,046	94.92%	
Hidalgo	Molina	1,584	125	7.89%	1,459	92.11%	48	3.29%	1,629	199	12.22%	1,430	87.78%	66	4.62%	1,022	71.47%	
	Superior	1,485	444	29.90%	1,041	70.10%	606	58.21%	1,853	241	13.01%	1,612	86.99%	591	36.66%	1,021	63.34%	
	United	865	751	86.82%	114	13.18%	14	1.62%	838	727	86.75%	111	13.25%	16	1.91%	95	85.59%	
	SDA Total	7,613	3,478	45.69%	4,135	54.31%	744	9.77%	7,491	3,236	43.20%	4,255	56.80%	729	9.73%	3,184	42.50%	
	Amerigroup	448	43	9.60%	405	90.40%	71	17.53%	464	50	10.78%	414	89.22%	75	18.12%	339	81.88%	
Jefferson	CHC	124	68	54.84%	56	45.16%	13	23.21%	127	81	63.78%	46	36.22%	11	23.91%	35	76.09%	
	Molina	1,651	21	1.273%	1,630	98.727%	8	5.56%	1,659	165	10.00%	1,494	89.00%	20	1.20%	57	42.54%	
	Texas Children's	2,231	208	9.32%	2,023	90.68%	587	29.02%	2,348	196	8.35%	2,152	91.65%	601	27.93%	1,176	54.65%	
	United	338	274	81.07%	64	18.93%	7	10.94%	321	263	81.93%	58	18.07%	4	6.90%	54	93.10%	
	SDA Total	3,306	614	18.57%	2,692	81.43%	686	20.75%	3,425	621	18.13%	2,804	81.87%	711	20.76%	1,661	48.50%	
Lubbock	Amerigroup	973	87	8.94%	886	91.06%	141	15.91%	1,007	78	7.75%	929	92.25%	150	16.15%	779	83.85%	
	FirstCare	1,305	202	15.48%	1,103	84.52%	129	11.70%	1,319	187	14.18%	1,132	85.82%	198	17.49%	934	82.51%	
	Superior	522	121	23.18%	401	76.82%	219	54.61%	571	83	14.54%	488	85.46%	165	33.81%	323	66.19%	
	SDA Total	2,800	410	14.64%	2,390	85.36%	489	17.46%	2,897	348	12.01%	2,549	87.99%	513	17.71%	2,036	70.28%	
	Amerigroup	1,397	138	9.88%	1,259	90.12%	231	18.35%	1,438	136	9.46%	1,302	90.54%	249	19.12%	1,053	80.88%	
MRSA Central	Scott & White	1,850	294	15.89%	1,556	84.11%	201	12.92%	1,636	282	17.24%	1,354	82.76%	233	17.21%	1,119	82.64%	
	Superior	909	267	29.37%	642	70.63%	352	54.83%	938	182	19.40%	756	80.60%	225	29.76%	531	70.24%	
	SDA Total	4,156	699	16.82%	3,457	83.18%	784	18.86%	4,012	600	14.96%	3,412	85.04%	707	17.62%	2,703	67.37%	
	Amerigroup	4,449	478	10.74%	3,971	89.26%	748	18.84%	4,665	513	11.00%	4,152	89.00%	824	19.85%	3,328	80.15%	
	Superior	1,010	294	29.11%	716	70.89%	348	48.60%	1,017	183	17.99%	834	82.01%	242	29.02%	592	70.98%	
MRSA Northeast	SDA Total	5,459	772	14.14%	4,687	85.86%	1,096	20.08%	5,682	696	12.25%	4,986	87.75%	1,066	18.76%	3,920	68.99%	
	Amerigroup	2,510	289	11.51%	2,221	88.49%	340	15.31%	2,603	273	10.49%	2,330	89.51%	380	16.31%	1,950	83.69%	
	FirstCare	1,664	189	11.36%	1,475	88.64%	153	10.37%	1,603	207	12.91%	1,396	87.09%	243	17.41%	1,153	82.59%	
	Superior	932	266	28.54%	666	71.46%	357	53.60%	1,093	194	17.75%	899	82.25%	265	29.48%	634	70.52%	
	SDA Total	5,106	744	14.57%	4,362	85.43%	850	16.65%	5,299	674	12.72%	4,625	87.28%	888	16.76%	3,737	70.52%	
MRSA West	Driscoll Children's	3,397	2,345	69.03%	1,052	30.97%	55	5.23%	3,015	2,264	75.09%	751	24.91%	59	7.86%	693	92.28%	
	Superior	357	62	17.37%	295	82.63%	161	54.58%	375	35	9.33%	340	90.67%	136	40.00%	204	60.00%	
	United	38	35	92.11%	3	7.89%	0	0.00%	3	100.00%	0	0.00%	7	15.22%	0	0.00%	7	100.00%
	SDA Total	3,792	2,442	64.40%	1,350	35.60%	216	5.70%	3,436	2,338	68.04%	1,098	31.96%	195	5.68%	904	26.31%	
	Aetha	161	119	73.91%	42	26.09%	0	0.00%	123	80	65.04%	43	34.96%	0	0.00%	43	100.00%	
Tarrant	Amerigroup	6,668	896	13.44%	5,772	86.56%	1,129	19.56%	7,173	868	12.10%	6,305	87.90%	1,390	22.05%	4,915	77.95%	
	Cook Children's	3,079	1,277	41.47%	1,802	58.53%	1,366	75.80%	2,834	993	35.04%	1,841	64.96%	1,345	73.06%	496	26.94%	
	SDA Total	9,908	2,292	23.13%	7,616	76.87%	2,495	25.18%	10,103	1,941	19.16%	8,164	80.84%	2,735	27.00%	5,454	53.84%	
	BCBS	4,901	465	9.49%	4,436	90.51%	1,346	30.34%	6,005	528	8.79%	5,477	91.21%	2,863	52.27%	2,574	47.00%	
	Dell	2,194	178	8.11%	2,016	91.89%	359	17.81%	2,249	186	8.27%	2,063	91.73%	395	19.15%	1,668	80.85%	
Travis	Superior	1,086	346	31.86%	740	68.14%	408	55.14%	1,158	202	17.44%	956	82.56%	328	34.31%	628	65.69%	
	SDA Total	8,181	989	12.09%	7,192	87.91%	2,113	25.83%	9,412	916	9.73%	8,496	90.27%	3,586	38.10%	4,870	57.14%	
	Statewide Total	95,525	20,063	21.00%	75,462	79.00%	19,347	20.25%	99,218	18,582	18.73%	80,636	81.27%	21,083	21.25%	54,729	55.16%	

**Attachment R1**  
**MCO Referrals to IG SFY21**  
**(Blanks = No Data Available)**

MCO	Quarter 1				Quarter 2			
	Sep-20	Oct-20	Nov-20	Total	Dec-20	Jan-21	Feb-21	Total
<b>Investigation Category</b>								
Program non-compliance	3	5		8	1	1	3	5
Non-appropriate billing	41	29	32	102	17	20	34	71
Billing for Services not Rendered		1		1				0
Quality of Care				0				0
Solicitation				0				0
Upcoding				0				0
Billing for Services After Death				0				0
Billing unnecessary services				0				0
Failure to disclose required info				0				0
Attendant Care FWA	1	3		4	1		1	2
Physical /Sexual Abuse of an Individual				0				0
<b>Total Referrals Received</b>	<b>45</b>	<b>38</b>	<b>32</b>	<b>115</b>	<b>19</b>	<b>21</b>	<b>38</b>	<b>78</b>
<b>Disposition Category</b>								
Returned to MCO to whatever action deemed appropriate				0				0
MPI Full scale investigation	3	5	3	11	5		1	6
Information transferred to existing full scale case				0				0
Preliminary Status				0		9	34	43
Referred to HHS-OIG (Federal)				0				0
Referred to Pharmacy Board	3	4	1	8				0
Referred to Medical Board		1		1	1			1
Referred to Vendor Drug				0				0
Closed	42	33	30	105	14	12	3	29
Pending Preliminary Investigation				0				0
Referred to MFCU	3	5	3	11	6			6
Transferred to IG Litigation				0				0
Transferred to IG Medical Services Division	4	2	6	12	2	4	1	7
Referred to Board of Psychologists				0				0
Referred to Board of Nurse Examiners				0				0
Referred to TX State Health Services	1			1				0
Referred to MCO/SIU		1		1				0
Referred to DADS				0				0
Referred to LPC Board				0				0
Referred to Texas Department of Licensing and Regulation (TDLR)		1		1				0
Refer to Utilization Review Division	1			1				0

MCO = Managed Care Organization  
OIG = Office of Inspector General

**Attachment R2**  
**Dental Plan Referrals to IG SFY21**  
**(Blanks = No Data Available)**

DMO	Quarter 1				Quarter 2			
	Sep-20	Oct-20	Nov-20	Total	Dec-20	Jan-21	Feb-21	Total
<b>Investigation Category</b>								
Program non-compliance				0				0
Non-appropriate billing	1	5	2	8	6	4	3	13
Billing for Services not Rendered				0				0
Billing unnecessary services				0				0
Solicitation				0				0
Quality of Care				0				0
<b>Total Referrals Received</b>	<b>1</b>	<b>5</b>	<b>2</b>	<b>8</b>	<b>6</b>	<b>4</b>	<b>3</b>	<b>13</b>
<b>Disposition Category</b>								
Returned to MCO to whatever action deemed appropriate				0				0
MPI Full scale investigation				0				0
Preliminary Investigation				0			3	3
Information transferred to existing full scale case				0				0
Closed	1	5	2	8	7	4		11
Provider Education				0				0
Transferred to IG Litigation				0				0
Transferred to OIG Medical Services Division			1	1	1			1
Referred to MFCU				0				0
Referred to Dental Board		1		1	3			3
Refer to MCO/SIU		1		1				0

DMO = Dental maintenance originazition  
MFCU = Medicaid Fraud Control Unit  
OIG = Office of Inspector General

Attachment V1  
STAR Claims Adjudication SFY21  
(Blanks = No Data Available)

MCO	Acute Care Claims						
	% Appealed Adjudicated within 30 Days (98% STD)						
	Quarter 1			Quarter 2			
	Sept	Oct	Nov	Sept	Oct	Nov	Nov
Aetna	57%	45%	49%	62%	98%		100%
Amerigroup	100%	100%	100%	100%	100%		100%
BCBS	100%	10%	13%	90%	100%		100%
Community First	99%	99%	99%	98%	99%		100%
Cook Children's	100%	100%	100%	67%	83%		100%
Dell	100%	100%	100%	100%	100%		100%
Driscoll Children's	100%	100%	100%	100%	100%		100%
El Paso Health	100%	100%	100%	100%	100%		100%
FirstCare	100%	100%	100%	100%	100%		100%
Molina	100%	100%	100%	100%	100%		100%
Parkland	53%	26%	40%	75%	100%		100%
Scott & White	100%	100%	100%	100%	100%		99%
Superior	100%	100%	100%	100%	100%		100%
Texas Children's	100%	100%	100%	100%	100%		100%
United	100%	100%	100%	100%	100%		100%



Attachment V1  
STAR Claims Adjudication SFY21  
(Blanks = No Data Available)

MCO	Acute Care Claims						
	% Clean Adjudicated within 30 days (98% STD)						
	Quarter 1			Quarter 2			
	Sept	Oct	Nov	Sept	Oct	Nov	
Aetna	98%	98%	98%	96%	97%	99%	
Amerigroup	100%	100%	100%	100%	99%	100%	
BCBS	100%	100%	100%	100%	100%	100%	
CHC	100%	100%	100%	100%	100%	100%	
Community First	100%	100%	100%	98%	97%	100%	
Cook Children's	100%	100%	100%	100%	100%	100%	
Dell	100%	100%	100%	100%	100%	100%	
Driscoll Children's	100%	100%	100%	100%	100%	100%	
El Paso Health	100%	100%	100%	100%	100%	100%	
FirstCare	99%	96%	90%	93%	94%	98%	
Molina	99%	99%	98%	93%	91%	99%	
Parkland	99%	99%	98%	97%	98%	99%	
Scott & White	99%	95%	96%	96%	97%	99%	
Superior	100%	100%	100%	100%	100%	100%	
Texas Children's	100%	100%	100%	100%	100%	100%	
United	100%	100%	100%	100%	100%	100%	

**Attachment V1**  
**STAR Claims Adjudication SFY21**  
**(Blanks = No Data Available)**

Acute Care Claims						
% Clean Adjudicated within 90 Days (99% STD)						
MCO	Quarter 1			Quarter 2		
	Sept	Oct	Nov	Sept	Oct	Nov
Aetna	100%	100%	100%	100%	100%	100%
Amerigroup	100%	100%	100%	100%	100%	100%
BCBS	100%	100%	100%	100%	100%	100%
CHC	100%	100%	100%	100%	100%	100%
Community First	100%	100%	100%	100%	100%	100%
Cook Children's	100%	100%	100%	100%	100%	100%
Dell	100%	100%	100%	100%	100%	100%
Driscoll Children's	100%	100%	100%	100%	100%	100%
El Paso Health	100%	100%	100%	100%	100%	100%
FirstCare	100%	100%	100%	100%	100%	100%
Molina	100%	100%	100%	100%	100%	100%
Parkland	100%	100%	100%	100%	100%	100%
Scott & White	100%	100%	100%	100%	100%	100%
Superior	100%	100%	100%	100%	100%	100%
Texas Children's	100%	100%	100%	100%	100%	100%
United	100%	100%	100%	100%	100%	100%

Attachment V1  
STAR Claims Adjudication SFY21  
(Blanks = No Data Available)

Behavioral Health Services Claims						
% Appealed Adjudicated within 30 Days (98% STD)						
MCO	Quarter 1			Quarter 2		
	Sept	Oct	Nov	Sept	Oct	Nov
Aetna	0%	33%	0%	67%	100%	100%
Amerigroup	100%	100%	97%	100%	99%	98%
Community First	100%	100%	100%	100%	100%	100%
Cook Children's	75%	100%	100%	100%	100%	100%
Dell	100%	100%	100%	100%		100%
Driscoll Children's	100%	100%	100%	100%	100%	99%
El Paso Health	100%	100%	100%	100%		
FirstCare	100%	100%	100%	100%	100%	100%
Molina	100%	100%	100%	100%	100%	100%
Parkland	100%	100%	100%	100%	100%	100%
Scott & White		100%		100%	100%	100%
Superior	100%	100%	100%	100%	100%	100%
Texas Children's	100%	100%	100%	100%	100%	100%
United	100%	100%	100%	100%	100%	100%

Attachment V1  
STAR Claims Adjudication SFY21  
(Blanks = No Data Available)

Behavioral Health Services Claims						
% Clean Adjudicated within 30 Days (98% STD)						
MCO	Quarter 1			Quarter 2		
	Sept	Oct	Nov	Sept	Oct	Nov
Aetna	99%	100%	99%	98%	99%	99%
Amerigroup	100%	100%	100%	100%	100%	100%
BCBS	100%	100%	100%	100%	100%	100%
CHC	100%	100%	100%	100%	100%	100%
Community First	100%	100%	100%	99%	98%	100%
Cook Children's	100%	100%	100%	100%	100%	100%
Dell	100%	99%	100%	100%	100%	100%
Driscoll Children's	100%	100%	100%	100%	100%	100%
El Paso Health	99%	100%	100%	100%	99%	100%
FirstCare	100%	83%	89%	91%	92%	98%
Molina	100%	100%	99%	97%	96%	100%
Parkland	100%	100%	100%	100%	100%	100%
Scott & White	100%	89%	93%	93%	87%	99%
Superior	100%	100%	100%	100%	100%	100%
Texas Children's	100%	100%	100%	100%	100%	100%
United	100%	100%	100%	100%	100%	100%

Attachment V1  
STAR Claims Adjudication SFY21  
Blanks = No Data Available)

	Behavioral Health Services Claims						
	% Clean Adjudicated within 90 Days (99% STD)						
	Quarter 1			Quarter 2			
	Sept	Oct	Nov	Sept	Oct	Nov	
Aetna	100%	100%	100%	100%	100%	100%	
Amerigroup	100%	100%	100%	100%	100%	100%	
BCBS	100%	100%	100%	100%	100%	100%	
CHC	100%	100%	100%	100%	100%	100%	
Community First	100%	100%	100%	100%	100%	100%	
Cook Children's	100%	100%	100%	100%	100%	100%	
Dell	100%	100%	100%	100%	100%	100%	
Driscoll Children's	100%	100%	100%	100%	100%	100%	
El Paso Health	100%	100%	100%	100%	100%	100%	
FirstCare	100%	100%	100%	100%	100%	100%	
Molina	100%	100%	100%	100%	100%	100%	
Parkland	100%	100%	100%	100%	100%	100%	
Scott & White	100%	100%	100%	100%	100%	100%	
Superior	100%	100%	100%	100%	100%	100%	
Texas Children's	100%	100%	100%	100%	100%	100%	
United	100%	100%	100%	100%	100%	100%	

Attachment V1  
STAR Claims Adjudication SFY21  
(Blanks = No Data Available)

Vision Services Claims						
% Appealed Adjusted within 30 Days (98% SDT)						
	Quarter 1			Quarter 2		
	Sept	Oct	Nov	Sept	Oct	Nov
MCO						
CHC		100%	100%	100%		
Cook Children's					100%	
Driscoll Children's				100%		
El Paso Health	100%	100%		100%		
FirstCare	100%	100%	100%	100%	100%	100%
Molina			100%	100%		
Superior	100%	100%	100%	100%	100%	100%
Texas Children's	100%	100%	100%	100%		

Attachment V1  
STAR Claims Adjudication SFY21  
(Blanks = No Data Available)

MCO	Vision Services Claims						
	% Clean Adjudicated within 30 Days (98% STD)						
	Quarter 1			Quarter 2			
	Sept	Oct	Nov	Sept	Oct	Nov	Nov
Aetna	100%	100%	100%	100%	100%	100%	100%
Amerigroup	100%	100%	100%	100%	100%	100%	100%
BCBS	100%	100%	100%	100%	100%	100%	100%
CHC	100%	100%	100%	100%	100%	100%	100%
Community First	100%	100%	100%	100%	100%	100%	100%
Cook Children's	100%	100%	100%	100%	100%	100%	100%
Dell	100%	100%	100%	100%	100%	100%	100%
Driscoll Children's	100%	100%	100%	100%	100%	100%	100%
El Paso Health	100%	100%	100%	100%	100%	100%	100%
FirstCare	100%	92%	92%	94%	97%	99%	99%
Molina	99%	100%	99%	97%	97%	100%	100%
Parkland	100%	100%	100%	100%	100%	100%	100%
Scott & White	100%	97%	98%	98%	99%	99%	99%
Superior	100%	100%	100%	100%	100%	100%	100%
Texas Children's	100%	100%	100%	100%	100%	100%	100%
United	100%	100%	100%	100%	100%	100%	100%

**Attachment V1**  
**STAR Claims Adjudication SFY21**  
**(Blanks = No Data Available)**

	Vision Services Claims						
	% Clean Adjudicated within 90 Days (99% STD)						
	Quarter 1			Quarter 2			
	Sept	Oct	Nov	Sept	Oct	Nov	Nov
MCO							
Aetna	100%	100%	100%	100%	100%	100%	100%
Amerigroup	100%	100%	100%	100%	100%	100%	100%
BCBS	100%	100%	100%	100%	100%	100%	100%
CHC	100%	100%	100%	100%	100%	100%	100%
Community First	100%	100%	100%	100%	100%	100%	100%
Cook Children's	100%	100%	100%	100%	100%	100%	100%
Dell	100%	100%	100%	100%	100%	100%	100%
Driscoll Children's	100%	100%	100%	100%	100%	100%	100%
El Paso Health	100%	100%	100%	100%	100%	100%	100%
FirstCare	100%	100%	100%	100%	100%	100%	100%
Molina	100%	100%	100%	100%	100%	100%	100%
Parkland	100%	100%	100%	100%	100%	100%	100%
Scott & White	100%	100%	100%	100%	100%	100%	100%
Superior	100%	100%	100%	100%	100%	100%	100%
Texas Children's	100%	100%	100%	100%	100%	100%	100%
United	100%	100%	100%	100%	100%	100%	100%



Attachment V1  
STAR Claims Adjudication SFY21  
(Blanks = No Data Available)

	Pharmacy Benefit Manager's Claims						
	% Clean Electronic Claims Adjudicated within 18 Days (98% STD)						
	Quarter 1			Quarter 2			
MCO	Sept	Oct	Nov	Sept	Oct	Nov	
Aetna	100%	100%	100%	100%	100%	100%	
Amerigroup	100%	100%	100%	100%	100%	100%	
BCBS	100%	100%	100%	100%	100%	100%	
CHC	100%	100%	100%	100%	100%	100%	
Community First	100%	100%	100%	100%	100%	100%	
Cook Childrens	100%	100%	100%	100%	100%	100%	
Dell	100%	100%	100%	100%	100%	100%	
Driscoll Children's	100%	100%	100%	100%	100%	100%	
El Paso Health	100%	100%	100%	100%	100%	100%	
FirstCare	100%	100%	100%	100%	100%	100%	
Molina	100%	100%	100%	100%	100%	100%	
Parkland		100%	100%	100%	100%	100%	
Scott & White	100%	100%	100%	100%	100%	100%	
Superior	100%	100%	100%	100%	100%	100%	
Texas Children's	100%	100%	100%	100%	100%	100%	
United	100%	100%	100%	100%	100%	100%	

Attachment V1  
STAR Claims Adjudication SFY21  
(Blanks = No Data Available)

MCO	Pharmacy Benefit Manager's Claims						
	% Clean Non-Electronic Claims Adjudicated within 21 Days (98% STD)						
	Quarter 1			Quarter 2			
	Sept	Oct	Nov	Sept	Oct	Nov	
Aetna		100%	100%				
Amerigroup	100%	100%	100%	100%	100%		
BCBS		100%					
CHC					100%		
Community First							
Cook Children's							
Dell							
FirstCare							
Driscoll Children's		100%			100%		
Molina	100%	100%		100%		100%	
Scott & White		100%					
Parkland							
Texas Children's	100%	100%	100%				100%

Attachment V2  
STAR+PLUS Claims Adjudication SFY21  
(Blanks = No Data Available)

Acute Care Claims						
% Appealed Adjudicated within 30 Days (98% STD)						
	Quarter 1			Quarter 2		
	Sept	Oct	Nov	Sept	Oct	Nov
MCO						
Amerigroup	99%	99%	100%	99%	100%	100%
Cigna-HealthSpring	100%	100%	100%	100%	100%	100%
Molina	100%	100%	100%	100%	100%	100%
Superior	100%	100%	100%	100%	100%	100%
United	100%	100%	100%	100%	100%	100%

Attachment V2  
STAR+PLUS Claims Adjudication SFY21  
(Blanks = No Data Available)

	Acute Care Claims						
	% Clean Adjudicated within 30 days (98% STD)						
	Quarter 1			Quarter 2			
	Sept	Oct	Nov	Sept	Oct	Nov	Nov
MCO							
Amerigroup	97%	95%	99%	98%	99%	100%	100%
Cigna-HealthSpring	100%	100%	99%	96%	100%	100%	100%
Molina	99%	99%	98%	93%	91%	99%	99%
Superior	100%	100%	99%	100%	100%	100%	100%
United	100%	100%	100%	100%	100%	99%	99%

Attachment V2  
STAR+PLUS Claims Adjudication SFY21  
(Blanks = No Data Available)

	Acute Care Claims						
	% Clean Adjudicated within 90 Days (99% STD)						
	Quarter 1			Quarter 2			
	Sept	Oct	Nov	Sept	Oct	Nov	Nov
MCO							
Amerigroup	100%	100%	100%	100%	100%	100%	100%
Cigna-HealthSpring	100%	100%	100%	100%	100%	100%	100%
Molina	100%	100%	100%	100%	100%	100%	100%
Superior	100%	100%	100%	100%	100%	100%	100%
United	100%	100%	100%	100%	100%	100%	100%

Attachment V2  
STAR+PLUS Claims Adjudication SFY21  
(Blanks = No Data Available)

	Behavioral Health Services Claims						
	% Appealed Adjudicated within 30 Days (98% STD)						
	Quarter 1			Quarter 2			
	Sept	Oct	Nov	Sept	Oct	Nov	Nov
MCO							
Amerigroup	100%	92%	100%	100%	100%	100%	100%
Cigna-HealthSpring	100%				100%		
Molina	100%	100%	100%	100%	100%	100%	100%
Superior	100%	100%	100%	100%	100%	100%	100%
United	100%	100%	100%	100%	100%	100%	100%

Attachment V2  
STAR+PLUS Claims Adjudication SFY21  
(Blanks = No Data Available)

MCO	Behavioral Health Services Claims						
	% Clean Adjudicated within 30 Days (98% STD)						
	Quarter 1			Quarter 2			
	Sept	Oct	Nov	Sept	Oct	Nov	Nov
Amerigroup	100%	99%	100%	100%	100%	100%	100%
Cigna-HealthSpring	100%	100%	100%	97%	100%	100%	100%
Molina	100%	100%	99%	97%	96%	100%	100%
Superior	100%	100%	100%	100%	97%	100%	100%
United	100%	100%	100%	100%	100%	100%	100%

Attachment V2  
STAR+PLUS Claims Adjudication SFY21  
(Blanks = No Data Available)

	Behavioral Health Services Claims						
	% Clean Adjudicated within 90 Days (99% STD)						
	Quarter 1			Quarter 2			
	Sept	Oct	Nov	Sept	Oct	Nov	Nov
MCO							
Amerigroup	100%	100%	100%	100%	100%	100%	100%
Cigna-HealthSpring	100%	100%	100%	100%	100%	100%	100%
Molina	100%	100%	100%	100%	100%	100%	100%
Superior	100%	100%	100%	100%	99%	100%	100%
United	100%	100%	100%	100%	100%	100%	100%



Attachment V2  
STAR+PLUS Claims Adjudication SFY21  
(Blanks = No Data Available)

	Vision Services Claims						
	% Appealed Adjusted within 30 Days (98% SDT)						
	Quarter 1			Quarter 2			
	Sept	Oct	Nov	Sept	Oct	Nov	
Molina	100%	100%	100%	100%	100%	100%	100%
Superior	100%	100%	100%	100%			100%

Attachment V2  
STAR+PLUS Claims Adjudication SFY21  
(Blanks = No Data Available)

	Vision Services Claims						
	% Clean Adjudicated within 30 Days (98% STD)						
	Quarter 1			Quarter 2			
	Sept	Oct	Nov	Sept	Oct	Nov	
MCO							
Amerigroup	100%	100%	100%	100%	100%	100%	100%
Cigna-HealthSpring	100%	100%	100%	100%	100%	100%	100%
Molina	100%	100%	100%	96%	97%		99%
Superior	100%	100%	100%	100%	100%	100%	100%
United	100%	100%	100%	100%	100%	100%	100%

Attachment V2  
STAR+PLUS Claims Adjudication SFY21  
(Blanks = No Data Available)

	Vision Services Claims						
	% Clean Adjudicated within 90 Days (99% STD)						
	Quarter 1			Quarter 2			
	Sept	Oct	Nov	Sept	Oct	Nov	Nov
MCO							
Amerigroup	100%	100%	100%	100%	100%	100%	100%
Cigna-HealthSpring	100%	100%	100%	100%	100%	100%	100%
Molina	100%	100%	100%	100%	100%	100%	100%
Superior	100%	100%	100%	100%	100%	100%	100%
United	100%	100%	100%	100%	100%	100%	100%

Attachment V2  
 STAR+PLUS Claims Adjudication SFY21  
 (Blanks = No Data Available)

	Pharmacy Benefit Manager's Claims						
	% Clean Electronic Claims Adjudicated within 18 Days (98% STD)						
	Quarter 1			Quarter 2			
	Sept	Oct	Nov	Sept	Oct	Nov	Nov
MCO							
Amerigroup	100%	100%	100%	100%	100%	100%	100%
Cigna-HealthSpring	100%	100%	100%	100%	100%	100%	100%
Molina	100%	100%	100%	100%	100%	100%	100%
Superior	100%	100%	100%	100%	100%	100%	100%
United	100%	100%	100%	100%	100%	100%	100%

Attachment V2  
STAR+PLUS Claims Adjudication SFY21  
(Blanks = No Data Available)

	Pharmacy Benefit Manager's Claims						
	% Clean Non-Electronic Claims Adjudicated within 21 Days (98% STD)						
	Quarter 1			Quarter 2			
	Sept	Oct	Nov	Sept	Oct	Nov	Nov
MCO							
Amerigroup	100%	100%	100%	100%	100%	100%	100%
Cigna-HealthSpring		100%	100%		100%	100%	100%
Molina	100%	100%	100%	100%	100%	100%	100%

Attachment V2  
STAR+PLUS Claims Adjudication SFY21  
(Blanks = No Data Available)

	Long-term Services and Supports						
	% Appealed Adjudicated within 30 Days (98% STD)						
	Quarter 1			Quarter 2			
	Sept	Oct	Nov	Sept	Oct	Nov	Nov
MCO							
Amerigroup	100%	100%	100%	98%	100%	100%	100%
Cigna-HealthSpring	100%	100%	100%	100%	100%	100%	100%
Molina	100%	100%	100%	100%	100%	100%	100%
Superior	100%	100%	100%	100%	94%	100%	100%
United	99%	100%	100%	100%	100%	100%	100%

Attachment V2  
STAR+PLUS Claims Adjudication SFY21  
(Blanks = No Data Available)

	Long-term Services and Supports						
	% Clean Adjudicated within 30 Days (98% STD)						
	Quarter 1			Quarter 2			
	Sept	Oct	Nov	Sept	Oct	Nov	Nov
MCO							
Amerigroup	100%	100%	100%	100%	100%	100%	100%
Cigna-HealthSpring	100%	100%	99%	98%	100%	100%	100%
Molina	100%	100%	100%	96%	97%	98%	98%
Superior	100%	100%	100%	100%	100%	100%	100%
United	100%	100%	100%	100%	100%	100%	100%

Attachment V2  
STAR+PLUS Claims Adjudication SFY21  
(Blanks = No Data Available)

MCO	Long-term Services and Supports						
	% Clean Adjudicated within 90 Days (99% STD)						
	Quarter 1			Quarter 2			
	Sept	Oct	Nov	Sept	Oct	Nov	Nov
Amerigroup	100%	100%	100%	100%	100%	100%	100%
Cigna-HealthSpring	100%	100%	100%	100%	100%	100%	100%
Molina	100%	100%	100%	100%	100%	100%	100%
Superior	100%	100%	100%	100%	100%	100%	100%
United	100%	100%	100%	100%	100%	100%	100%



**Attachment V2**  
**STAR+PLUS Claims Adjudication SFY21**  
**(Blanks = No Data Available)**

SDA	Dental Program	Measure	Dental Claims					
			Quarter 1			Quarter 2		
			Sept	Oct	Nov	Sept	Oct	Nov
Statewide	DentaQuest	Dental Clean 30	99%	100%	98%	100%	100%	100%
		Dental Appealed 30	100%	100%	99%	100%	99%	100%
		Dental Clean 90	100%	100%	100%	100%	100%	100%
	MCNA	Dental Clean 30	100%	100%	100%	100%	100%	100%
		Dental Appealed 30	100%	98%	100%	100%	100%	100%
		Dental Clean 90	100%	100%	100%	100%	100%	100%
	United	Dental Clean 30	100%	100%	100%	100%	100%	100%
		Dental Appealed 30			100%	100%	100%	100%
		Dental Clean 90	100%	100%	100%	100%	100%	100%
		Dental Clean 90	100%	100%	100%	100%	100%	100%

Attachment V4  
STAR Kids Claims Adjudication SFY21  
(Blanks = No Data Available)

Acute Care Claims						
% Appealed Adjudicated within 30 Days (98% STD)						
MCO	Quarter 1			Quarter 2		
	Sept	Oct	Nov	Sept	Oct	Nov
Aetna	46%	41%	40%	69%	97%	100%
Amerigroup	100%	97%	100%	99%	100%	100%
BCBS	100%	11%	65%	100%	100%	100%
Children's Medical Center	100%	100%	100%	100%	100%	100%
Community First	100%	100%	99%	100%	100%	100%
Cook Children's	100%	100%	100%	50%	100%	100%
Driscoll Children's	100%	100%	100%	100%	100%	99%
Superior	100%	100%	99%	100%	100%	100%
Texas Children's	100%	100%	100%	100%	100%	100%
United	100%	100%	100%	100%	100%	100%

Attachment V4  
STAR Kids Claims Adjudication SFY21  
(Blanks = No Data Available)

Acute Care Claims						
% Clean Adjudicated within 30 days (98% STD)						
MCO	Quarter 1			Quarter 2		
	Sept	Oct	Nov	Sept	Oct	Nov
Aetna	99%	99%	99%	99%	97%	99%
Amerigroup	96%	100%	99%	100%	100%	100%
BCBS	100%	100%	100%	100%	100%	100%
Children's Medical Center	100%	100%	100%	100%	100%	100%
Community First	100%	100%	100%	100%	99%	100%
Cook Children's	100%	100%	100%	100%	100%	99%
Driscoll Children's	100%	100%	100%	100%	100%	100%
Superior	100%	100%	100%	100%	100%	100%
Texas Children's	100%	100%	100%	100%	100%	100%
United	100%	100%	100%	100%	100%	100%

**Attachment V4**  
**STAR Kids Claims Adjudication SFY21**  
**(Blanks = No Data Available)**

<b>Acute Care Claims</b>						
<b>% Clean Adjudicated within 90 Days (99% STD)</b>						
	<b>Quarter 1</b>			<b>Quarter 2</b>		
	<b>Sept</b>	<b>Oct</b>	<b>Nov</b>	<b>Sept</b>	<b>Oct</b>	<b>Nov</b>
<b>MCO</b>						
Aetna	100%	100%	100%	100%	100%	100%
Amerigroup	100%	100%	100%	100%	100%	100%
BCBS	100%	100%	100%	100%	100%	100%
Children's Medical Center	100%	100%	100%	100%	100%	100%
Community First	100%	100%	100%	100%	100%	100%
Cook Children's	100%	100%	100%	100%	100%	100%
Driscoll Children's	100%	100%	100%	100%	100%	100%
Superior	100%	100%	100%	100%	100%	100%
Texas Children's	100%	100%	100%	100%	100%	100%
United	100%	100%	100%	100%	100%	100%

Attachment V4  
STAR Kids Claims Adjudication SFY21  
(Blanks = No Data Available)

Behavioral Health Services Claims						
% Clean Adjudicated within 30 Days (98% STD)						
MCO	Quarter 1			Quarter 2		
	Sept	Oct	Nov	Sept	Oct	Nov
Aetna				100%	100%	100%
Amerigroup	100%	100%	100%	100%	100%	100%
Children's Medical Center	100%	100%		100%	100%	100%
Community First	99%	100%	98%	100%	100%	100%
Cook Children's		100%	100%		100%	100%
Driscoll Children's	100%	100%	100%	100%	100%	100%
Superior	100%	100%	100%	100%	100%	100%
Texas Children's	100%	100%	100%	100%	100%	100%
United	100%	100%	100%	100%	100%	100%

**Attachment V4**  
**STAR Kids Claims Adjudication SFY21**  
**(Blanks = No Data Available)**

	Behavioral Health Services Claims						
	% Clean Adjudicated within 30 Days (98% STD)						
	Quarter 1			Quarter 2			
	Sept	Oct	Nov	Sept	Oct	Nov	
MCO							
Aetna	100%	100%	99%	99%	98%	99%	
Amerigroup	99%	100%	100%	100%	100%	100%	
BCBS	100%	100%	100%	100%	100%	100%	
Children's Medical Center	100%	100%	100%	100%			
Community First	100%	100%	100%	100%	99%	100%	
Cook Children's	100%	100%	100%	100%	100%	100%	
Driscoll Children's	100%	100%	100%	100%	100%	100%	
Superior	100%	100%	100%	100%	100%	100%	
Texas Children's	100%	100%	100%	100%	100%	100%	
United	100%	100%	100%	100%	100%	100%	

Attachment V4  
STAR Kids Claims Adjudication SFY21  
(Blanks = No Data Available)

	Behavioral Health Services Claims						
	% Clean Adjudicated within 90 Days (99% STD)						
	Quarter 1			Quarter 2			
	Sept	Oct	Nov	Sept	Oct	Nov	Nov
MCO							
Aetna	100%	100%	100%	100%	100%	100%	100%
Amerigroup	100%	100%	100%	100%	100%	100%	100%
BCBS	100%	100%	100%	100%	100%	100%	100%
Children's Medical Center	100%	100%	100%	100%			
Community First	100%	100%	100%	100%	100%	100%	100%
Cook Children's	100%	100%	100%	100%	100%	100%	100%
Driscoll Children's	100%	100%	100%	100%	100%	100%	100%
Superior	100%	100%	100%	100%	100%	100%	100%
Texas Children's	100%	100%	100%	100%	100%	100%	100%
United	100%	100%	100%	100%	100%	100%	100%

**Attachment V4**  
**STAR Kids Claims Adjudication SFY21**  
**(Blanks = No Data Available)**

	Vision Services Claims						
	% Appealed Adjusted within 30 Days (98% SDT)						
	Quarter 1			Quarter 2			
	Sept	Oct	Nov	Sept	Oct	Nov	
<b>MCO</b>							
Driscoll Children's				100%			
Superior					100%		
Texas Children's	100%						



Attachment V4  
STAR Kids Claims Adjudication SFY21  
(Blanks = No Data Available)

MCO	Vision Services Claims						
	% Clean Adjudicated within 30 Days (98% STD)						
	Quarter 1			Quarter 2			
	Sept	Oct	Nov	Sept	Oct	Nov	
Aetna	100%	100%	100%	100%	100%	100%	100%
Amerigroup	100%	100%	100%	100%	100%	100%	100%
BCBS	100%	100%	100%	100%	100%	100%	100%
Children's Medical Center	100%	100%	100%	100%			
Community First	100%	100%	100%	100%	100%	100%	100%
Cook Children's	100%	100%	100%	100%	100%	100%	100%
Driscoll Children's	100%	100%	100%	100%	100%	100%	100%
Superior	100%	100%	100%	100%	100%	100%	100%
Texas Children's	100%	100%	100%	100%	100%	100%	100%
United	100%	100%	100%	100%	100%	100%	100%

Attachment V4  
STAR Kids Claims Adjudication SFY21  
(Blanks = No Data Available)

Vision Services Claims	
% Clean Adjudicated within 90 Days (99% STD)	
MCO	Quarter 1
	Sept Oct Nov
Aetna	100% 100% 100%
Amerigroup	100% 100% 100%
BCBS	100% 100% 100%
Children's Medical Center	100% 100% 100%
Community First	100% 100% 100%
Cook Children's	100% 100% 100%
Driscoll Children's	100% 100% 100%
Superior	100% 100% 100%
Texas Children's	100% 100% 100%
United	100% 100% 100%

**Attachment V4**  
**STAR Kids Claims Adjudication SFY21**  
**(Blanks = No Data Available)**

	Pharmacy Benefit Manager's Claims						
	% Clean Electronic Claims Adjudicated within 18 Days (98% STD)						
	Quarter 1			Quarter 2			
	Sept	Oct	Nov	Sept	Oct	Nov	
MCO							
Aetna	100%	100%	100%	100%	100%	100%	100%
Amerigroup	100%	100%	100%	100%	100%	100%	100%
BCBS	100%	100%	100%	100%	100%	100%	100%
Childrens Medical Center	100%	100%					
Community First	100%	100%	100%	100%	100%	100%	100%
Cook Children's	100%	100%	100%	100%	100%	100%	100%
Driscoll Children's	100%	100%	100%	100%	100%	100%	100%
Superior	100%	100%	100%	100%	100%	100%	100%
Texas Children's	100%	100%	100%	100%	100%	100%	100%
United	100%	100%	100%	100%	100%	100%	100%

Attachment V4  
 STAR Kids Claims Adjudication SFY21  
 (Blanks = No Data Available)

	Pharmacy Benefit Manager's Claims						
	% Clean Non-Electronic Claims Adjudicated within 21 Days (98% STD)						
	Quarter 1			Quarter 2			
	Sept	Oct	Nov	Sept	Oct	Nov	
MCO							
Aetna	100%						
Amerigroup	100%			100%	100%		
BCBS	100%		100%		100%		
Driscoll Children's							
Texas Children's	100%	100%	100%	100%			

Attachment V4  
STAR Kids Claims Adjudication SFY21  
(Blanks = No Data Available)

Long-term Services and Supports							
% Appealed Adjudicated within 30 Days (98% STD)							
MCO	Quarter 1			Quarter 2			
	Sept	Oct	Nov	Sept	Oct	Nov	Nov
Aetna	0%				100%	100%	100%
Amerigroup	100%	100%	100%	100%	100%	100%	100%
BCBS				100%		100%	100%
Children's Medical Center	100%	100%		100%	100%	100%	100%
Community First	100%	98%	99%	100%	100%	100%	100%
Cook Children's	100%			100%	100%	100%	100%
Driscoll Children's	100%	95%	100%	100%	99%	100%	100%
Superior	100%	100%	100%				
Texas Children's	100%	100%	100%				

**Attachment V4**  
**STAR Kids Claims Adjudication SFY21**  
**(Blanks = No Data Available)**

Long-term Services and Supports						
% Clean Adjudicated within 30 Days (98% STD)						
MCO	Quarter 1			Quarter 2		
	Sept	Oct	Nov	Sept	Oct	Nov
Aetna	100%	100%	99%	100%	98%	100%
Amerigroup	100%	100%	100%	100%	100%	100%
BCBS	100%	100%	100%	100%	100%	100%
Childrens Medical Center	100%	100%	100%	98%	100%	100%
Community First	100%	100%	100%	100%	100%	100%
Cook Children's	100%	100%	100%	100%	100%	100%
Driscoll Children's	100%	100%	100%	100%	100%	100%
Superior	100%	100%	100%	100%	100%	100%
Texas Children's	100%	100%	100%	100%	100%	100%
United	100%	100%	100%	100%	100%	100%

**Attachment V4**  
**STAR Kids Claims Adjudication SFY21**  
**(Blanks = No Data Available)**

	Long-term Services and Supports						
	% Clean Adjudicated within 90 Days (99% STD)						
	Quarter 1			Quarter 2			
	Sept	Oct	Nov	Sept	Oct	Nov	Nov
MCO							
Aetna	100%	100%	100%	100%	100%	100%	100%
Amerigroup	100%	100%	100%	100%	100%	100%	100%
BCBS	100%	100%	100%	100%	100%	100%	100%
Children's Medical Center	100%	100%	100%	100%	100%	100%	100%
Community First	100%	100%	100%	100%	100%	100%	100%
Cook Children's	100%	100%	100%	100%	100%	100%	100%
Driscoll Children's	100%	100%	100%	100%	100%	100%	100%
Superior	100%	100%	100%	100%	100%	100%	100%
Texas Children's	100%	100%	100%	100%	100%	100%	100%
United	100%	100%	100%	100%	100%	100%	100%

RHP	Describe your RHP's progress during DY9	Describe lessons learned	Describe other challenges within your RHP during DY9	Describe any other pertinent findings from your RHP during DY9	Describe any challenges and other pertinent findings from your RHP due to COVID-19																																												
RHP01	<p>Region Overview</p> <p>The Northeast Texas Regional Healthcare Partnership (RHP 1) is comprised of 28 counties: Anderson, Bowie, Camp, Cass, Cherokee, Delta, Fannin, Franklin, Freestone, Gregg, Harrison, Henderson, Hopkins, Houston, Hunt, Lamar, Marion, Morris, Panola, Rains, Red River, Rusk, Smith, Titus, Trinity, Upshur, Van Zandt and Wood.</p> <p>Northeast Texas RHP 1 continued its progress on meeting community needs during the DY9 (October 1, 2019 - September 30, 2020) time period. The following is a summary of that progress and the work of the Anchor and RHP 1 Performing Providers.</p> <p>Development and Updating of the RHP</p> <p>In 2012, the development of the RHP 1 Plan began with a region-wide community needs assessment that looked at the existing healthcare environment and identified the challenges that are unique to the patients of the region. Through this assessment, six major community needs were identified: 1) insufficient access to primary and specialty care services; 2) insufficient access to mental and behavioral health services; 3) high rates of chronic disease; 4) high costs due to potentially preventable hospitalizations; 5) inappropriate emergency department utilization; and 6) efficiency in and effectiveness of health care delivery. RHP 1 DSRIP</p>	<p>Northeast Texas Providers (RHP 1) continue to make progress toward transforming health care delivery and meeting system performance and regional goals. Lessons learned by RHP-1 performing providers during DY9 through measure bundle implementation and continuous quality improvement activities are varied but are significantly associated with the severity of the impact of the COVID-19 pandemic. To provide an accurate picture of some of those lessons, a selection of Provider response on this topic is included below:</p> <ul style="list-style-type: none"><li>- Provider has established a sustainable training program with our providers for educating patients, stronger patient prescription compliance, patient self-management of hypertension and increased primary care provider referrals to cardiovascular specialty care.</li><li>- This (learning collaborative) information allowed a community mental health center to adjust accordingly by redistributing resources to ensure many face-to-face provider visits be obtained through tele-video contact.</li><li>- Provider has implemented several HL-7 feeds to improve the crossing of documentation from one EMR to another, thus improving continuity of care</li></ul> <p>There were many lessons learned throughout the RHP in DY9. The major themes are highlighted below:</p> <ul style="list-style-type: none"><li>Adaptability</li><li>Every provider has been affected by COVID-19. Normal operations are not fully restored throughout RHP 2 but the patient needs must still (attempt to) be met.</li><li>Many providers had to launch a telemedicine practice where one had not previously existed.</li><li>Patient expectations on how care should be delivered are forever changed based off of the events of this year.</li><li>Commitment to Engage Patients</li><li>Enhancing understanding of patient flow through multiple provider systems allows for the region as a whole to be more consistent in the language and strategies used to reach out to patients.</li><li>Understanding the health literacy and communication preferences of your patient population continues to be critical to successful implementation of change.</li><li>Providers are continuing to experiment with proactive patient outreach strategies, as they are vital to maintain engagement and compliance. This</li></ul>	<p>Compliance monitoring activities conducted with Myers &amp; Stauffer (MSLC) have presented challenges to DSRIP Performing Providers and has been much more administratively burdensome than anticipated. In many situations, the level of detail requested by MSLC has differed from the provider understood measure specification and has led to a manual review of medical records for data extraction. In conjunction with the compliance audit requests, providers have emerged in the COVID-19 pandemic with clinical capacity and staffing issues. Ultimately, with resources shifted towards the pandemic, project teams have been taxed to provide information to MSLC promptly.</p> <p>Providers have increased and/or enhanced their use of telehealth; however, this implementation has required the establishment of new procedures, additional staff training, and re-evaluation of data capturing methodologies. For example, paper-based assessments provided via office visits are being administered over the phone and then documented into the medical record.</p> <p>Provider recruitment and retention are continually cited as challenges for rural Northeast Texas Providers. Recruitment challenges are being</p>	<p>RHP 1 has made significant strides in moving towards regional health care transformation. As we prepare for DY 10 and the phase out of DSRIP, we encourage HHSC and CMS to allow the Providers adequate time to fully implement all the necessary program and policy decisions and system modifications that will be needed to successfully transition.</p>	<p>During DY9, the COVID-19 pandemic has had a significant impact on the activities conducted by the RHP. For two months, March and April 2020, non-urgent services were discontinued for hospital providers, and clinic volumes decreased. As providers shifted their focus on meeting the immediate needs of patients diagnosed with COVID-19 or who had been potentially exposed to COVID-19, provider resources were re-allocated to perform such services as critical care delivery, onsite testing, and contact tracing. With low clinic volumes and decreased available staff, some elements of project measures were unable to be continued as previously performed. Proactively, providers shifted to the use or expanded the use of telehealth or telemedicine. This service delivery change required the implementation of new processes and protocols, which increased the startup time and limited access to primary care services. Once shifting to telehealth visits, providers began to perform screening assessments such as the PHQ9 via the phone to capture metric data.</p> <p>The noticeable trend in RHP 1 has been the increase in telehealth services. However, RHP 1's rural communities presented challenges related to</p> <p>Every DSRIP performing provider, as well as the UC only hospitals in the region, were significantly impacted by COVID-19. All providers saw a change in the way care was delivered, as the majority of in-person ambulatory visits were either postponed or shifted to virtual (either phone or video) visits for months during the year. All planned in-person learning collaborative activities (in March, June and September) were cancelled. Providers have all been focused on "crisis management" as the local and state mandates have changed, as well as the changing needs of the patient populations they serve. Larger hospitals have seen additional critical transfers, as the smaller facilities saw their capabilities and capacities exceeded. Providers noted that staff with positive COVID tests, as well as those quarantined for potential exposure, had also caused a significant impact to their ability to offer services.</p> <p>As DY9 came to a close, providers were attempting to get as much back to normal as possible, with varying levels of success; all organizations noted a significant reticence of the patient population to seek out preventive care, so focused outreach and marketing is in progress throughout the region. With the rising COVID-19 rates in the early part of</p>																																												
RHP02	<p>In DY9, RHP 2 supported efforts regarding Category C reporting (PY2 as well as corrections to baseline and PY1), and provided continued readiness support for compliance review. Reporting (including NMIs) was supported. Focused efforts regarding cost and savings were conducted. Stakeholder engagement and learning collaborative virtual meetings were held to support performing providers as they continued their way under the Waiver 2.0 rules package and in accordance with COVID-related concerns.</p> <table><tr><th>Date</th><th>Time</th><th>Event</th></tr><tr><td>Location</td><td></td><td></td></tr><tr><td>10/02/2019</td><td>10:00am</td><td>Nacogdoches Memorial</td></tr><tr><td>Plan Template Discussion</td><td></td><td>phone call</td></tr><tr><td>10/02/2019</td><td>3:00pm</td><td>Coastal Health &amp; Wellness L1-186 Discussion</td></tr><tr><td>10/03/2019</td><td>9:45am</td><td>Christus SE DY8</td></tr><tr><td>Reporting Discussion</td><td></td><td>phone call</td></tr><tr><td>10/03/2019</td><td>11:00am</td><td>Gulf Coast Center Plan</td></tr><tr><td>Template Discussion</td><td></td><td>phone call</td></tr><tr><td>10/03/2019</td><td>2:30pm</td><td>Woodland Heights Plan</td></tr><tr><td>Template Discussion</td><td></td><td>phone call</td></tr><tr><td>10/04/2019</td><td>10:00am</td><td>HHSC DY8 October</td></tr><tr><td>Reporting</td><td></td><td>webinar</td></tr><tr><td>10/08/2019</td><td>9:00am</td><td>RHP 2 Learning</td></tr><tr><td>Collaborative</td><td></td><td></td></tr></table>	Date	Time	Event	Location			10/02/2019	10:00am	Nacogdoches Memorial	Plan Template Discussion		phone call	10/02/2019	3:00pm	Coastal Health & Wellness L1-186 Discussion	10/03/2019	9:45am	Christus SE DY8	Reporting Discussion		phone call	10/03/2019	11:00am	Gulf Coast Center Plan	Template Discussion		phone call	10/03/2019	2:30pm	Woodland Heights Plan	Template Discussion		phone call	10/04/2019	10:00am	HHSC DY8 October	Reporting		webinar	10/08/2019	9:00am	RHP 2 Learning	Collaborative			<p>Pre-COVID-19, challenges that were common amongst providers remained consistent from prior years: recruiting/retaining clinical staff, broadening the reach of care coordination efforts to cover the full spectrum of providers, patient (non)adherence to treatment plans and preparing to deal with compliance audits. The continuing lessons learned from the details of the compliance audits have influenced the administrative efforts related to DSRIP, as the conversion to the organizational approach has required and extensive amount of planning/testing/validation to ensure that the data systems are sufficient to support the reporting requirements.</p> <p>Staffing/Workforce</p> <ul style="list-style-type: none"><li>General workforce availability and workforce training.</li><li>The lack of mental health providers in the region, especially given the behavioral health focus and many mental health centers in Region 2.</li><li>Retaining skilled providers and staff remains a challenge. Post DSRIP 1.0 has seen some performing providers with significant structural changes in order to better support the systemic deliverables.</li><li>Competition for positions is high in our geographic</li></ul>	<p>RHP 2 spent the first few months of DY9 working on the Category C outcomes, both at the local (organizational) and regional level; those efforts shifted in mid-March when the local and state level impacts of COVID-19 began to be felt. Nearly all DSRIP specific activities, as well as normal operations, were affected for every performing provider. The changes to care delivery, including the rushed implementation of telehealth services where they had not previously been in place, fundamentally changes the way that providers support their patients – but may not be in full alignment with DSRIP specifications as they currently stand. These concerns need to be factored in as plans are finalized for post-DSRIP.</p>	<p>Every DSRIP performing provider, as well as the UC only hospitals in the region, were significantly impacted by COVID-19. All providers saw a change in the way care was delivered, as the majority of in-person ambulatory visits were either postponed or shifted to virtual (either phone or video) visits for months during the year. All planned in-person learning collaborative activities (in March, June and September) were cancelled. Providers have all been focused on "crisis management" as the local and state mandates have changed, as well as the changing needs of the patient populations they serve. Larger hospitals have seen additional critical transfers, as the smaller facilities saw their capabilities and capacities exceeded. Providers noted that staff with positive COVID tests, as well as those quarantined for potential exposure, had also caused a significant impact to their ability to offer services.</p> <p>As DY9 came to a close, providers were attempting to get as much back to normal as possible, with varying levels of success; all organizations noted a significant reticence of the patient population to seek out preventive care, so focused outreach and marketing is in progress throughout the region. With the rising COVID-19 rates in the early part of</p>
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RHP03	<p><b>Regional Implementation</b></p> <p>RHP3 Providers started off DY9 with the October DY8R2 semi-annual reporting which included the submission of the costs and savings analysis for most participating Providers. Additionally, many Providers submitted their Category C quality measure data for PY1 during this reporting cycle. In order to support Providers in their pursuit of report accuracy, the Anchor offered technical assistance by means of verifying measure specifications, explaining reporting requirements, and connecting Providers to others working on the same measure(s). The MSC audit process began in DY9, round 1 was completed and round 2 was initiated during this year. The audits have helped provide clarity and confirmation on the data collection and reporting process for Providers to ensure data integrity in their reporting.</p> <p>The COVID-19 pandemic severely impacted Providers this year. The pandemic, which began in the early Spring of 2020, has had far reaching implications for the RHP3 Providers as well as the community members they serve. Providers have faced location closures, the cancellation of elective procedures and preventative services, redeployment of staff, and managing the impacts of COVID alongside the normal healthcare needs of the</p>	<p><b>Regional Governance</b></p> <p>The areas of concern shifted significantly in DY9 for regional governance due to the COVID-19 pandemic. Prior to the pandemic, concerns centered on data sharing and post-DSRIP transition; since the pandemic, concerns have shifted to managing pandemic response while ensuring that the DSRIP requirements are met.</p> <p>Providers continue to be frustrated by the unavailability of shared data to use in supporting the Region's ability to report on healthcare services delivered across systems and to collaborate on interventions. The Region's HIE, Greater Houston Health Connect, has connected many Providers to its health information exchange platform. The platform is used by front-line healthcare staff during patient visits to gather information about recent healthcare services the patient has had. The HIE sought to assist regional DSRIP Providers in collating data to more accurately calculate their numerators, however, the collating method would have been completely manual on the Providers' side. Region 3 Providers with large denominator populations did not see this as a feasible option. The HIE has discussed potentially building a population level query platform but it is not in place at this time. Some Providers that use EPIC were</p>	<p>DY9 brought many new challenges for Providers; the COVID-19 pandemic, confirming data accuracy with audits, DSRIP fatigue, and planning for DSRIP transition.</p> <p>Challenges with protocols and specifications continued in DY9. Though many Providers had a better understanding with the Category C requirements than in previous years, there were still many Providers who had outstanding TA flags well into DY9. Providers underwent the first Category C audits in DY9, which were challenging due to the complications from the pandemic but also provided much clarity for providers in their reporting requirements moving forward.</p> <p>Engagement continues to present challenges. First, Regionwide calls intend to be collaborative in nature but at times participation falls short of expectations. Especially in a time with so many competing priorities as Providers navigate their response to COVID-19. Many of the same individuals participate as committee members. Utilizing the same individuals leads to the same ideas and conversations and hinders new ideas from coming to the forefront. Second, with the shift to webinar-based Learning Collaborative events in DY9, it was challenging to get participants to engage in this format. This format brought new challenges</p>	<p>The COVID-19 pandemic was the most challenging event that impacted the RHP 4 governance and performing providers during DY 9. The COVID-19 pandemic caused drastic fluctuations in patient volume and the providers' ability to do patient outreach, non-emergency surgeries, face to face visits, and more.</p> <p>With the exceptions allowed for COVID-19, most Region 4 Providers were able to achieve their measure goals that were reported in DY9R2. Specifically, the allowance for telemedicine/telehealth visits was instrumental in the providers' success. However, the DY10 reporting cycle may tell a different story when the Category C measures are reported for calendar year 2020. Many rural Providers have limited staff resources and DSRIP responsibilities are added to an existing staff person that already has a full-time workload. In DY 9, RHP 4 also experienced new performing provider staff that were not familiar with DSRIP and had a significant learning curve to understand the nuances of the DSRIP program.</p> <p>Following is a summary of the most common challenges as identified by RHP 4 Performing Providers:</p>	<p>RHP 4 Providers have made progress toward transformation and meeting system performance and regional goals. Through the activities of RHP 4, Providers have learned valuable lessons to transform the RHP 4 delivery system, including the use of national measure stewards. The efforts towards sustainability, alternative payment methodologies, and integration with Medicaid managed care organizations are challenging, especially for a rural RHP that does not have the volume of patients to pique interest and engagement of the managed care organizations (MCOs), nor are they in a position to take any level of financial risk. In some cases, sustainability will depend on the funding available through the state or local governmental entities.</p> <p>Another RHP 4 lesson learned is the importance of collaboration among all Providers and stakeholders in the community to create a vision that is supported by all entities. Education of the patients is critical to our success and more work is needed to change the learned behavior of the patients' experience with the health care system.</p> <p>Additionally, during DY 9, in the two learning collaborative meetings, time was dedicated to discussions on sustainability and DY11 DSRIP</p>	<p>RHP 5 anchor has continuously worked with all of our performing providers to meet the needs that were identified in the community needs assessment that was updated in 2018. All of the current providers continue to provide a high level of care and meet all metrics as well as all providers continue to engage our community despite the challenges that have been caused due to COVID. RHP 5 website has been updated and changed to a different site and is up to date.</p> <p>(http://www.hchd.org/153/Texas-Regional-Healthcare-Partnership-Re) RHP 5 participated in the virtual learning collaborative series held by RHP 4. All of our providers were provided with all of the Anchor notes distributed by the state and invited to attend any of the learning collaboratives being held. Our RHP did not have a learning collaborative due to the current COVID situation in our area.</p>	<p><b>Progress Meeting Community Needs</b></p> <p>RHP 5 anchor has continuously worked with all of our performing providers to meet the needs that were identified in the community needs assessment that was updated in 2018. All of the current providers continue to provide a high level of care and meet all metrics as well as all providers continue to engage our community despite the challenges that have been caused due to COVID. RHP 5 website has been updated and changed to a different site and is up to date.</p> <p>(http://www.hchd.org/153/Texas-Regional-Healthcare-Partnership-Re) RHP 5 participated in the virtual learning collaborative series held by RHP 4. 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RHP04	<p><b>Regional Healthcare Partnership (RHP) 4</b></p> <p>comprised of 18 counties in South Texas including Aransas, Bee, Brooks, DeWitt, Duval, Goliad, Gonzales, Jackson, Jim Wells, Karnes, Kennedy, Kleberg, Lavaca, Live Oak, Nueces, Refugio, San Patricio, and Victoria. Most Region 4 counties are located within the Coastal Bend Council of Government (Coastal Bend-COG) geographic area. The Coastal Bend COG includes all the counties of Region 4 except Gonzales, Jackson, Lavaca, and Victoria. The region is a mix of suburban, urban, and rural areas and while it is geographically large (almost twice the size of Region 3 - Harris County) it has a relatively small population of 786,000 (about one-sixth the population size of Region 3).</p> <p>The Nueces County Hospital District, Jonny Hipp, is the Anchor for RHP 4. The RHP 4 Anchor communicates weekly with the providers sharing information on DSRIP policies, changes, and guidelines for reporting. The RHP 4 Anchor also hosts learning collaboratives, webinars, and conference calls to encourage provider participation and shared communication across the region as well as keeps current updates posted to the Anchor website.</p>	<p>RHP 4 Providers have made progress toward transformation and meeting system performance and regional goals. Through the activities of RHP 4, Providers have learned valuable lessons to transform the RHP 4 delivery system, including the use of national measure stewards. The efforts towards sustainability, alternative payment methodologies, and integration with Medicaid managed care organizations are challenging, especially for a rural RHP that does not have the volume of patients to pique interest and engagement of the managed care organizations (MCOs), nor are they in a position to take any level of financial risk. In some cases, sustainability will depend on the funding available through the state or local governmental entities.</p> <p>Another RHP 4 lesson learned is the importance of collaboration among all Providers and stakeholders in the community to create a vision that is supported by all entities. Education of the patients is critical to our success and more work is needed to change the learned behavior of the patients' experience with the health care system.</p> <p>Additionally, during DY 9, in the two learning collaborative meetings, time was dedicated to discussions on sustainability and DY11 DSRIP</p>	<p>RHP 4 Providers have made progress toward transformation and meeting system performance and regional goals. Through the activities of RHP 4, Providers have learned valuable lessons to transform the RHP 4 delivery system, including the use of national measure stewards. 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Many rural Providers have limited staff resources and DSRIP responsibilities are added to an existing staff person that already has a full-time workload. In DY 9, RHP 4 also experienced new performing provider staff that were not familiar with DSRIP and had a significant learning curve to understand the nuances of the DSRIP program.</p> <p>Following is a summary of the most common challenges as identified by RHP 4 Performing Providers:</p>	<p>RHP 4 Providers have made progress toward transformation and meeting system performance and regional goals. Through the activities of RHP 4, Providers have learned valuable lessons to transform the RHP 4 delivery system, including the use of national measure stewards. 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RHP05	<p><b>Regional Healthcare Partnership (RHP) 5</b></p> <p>comprised of 18 counties in South Texas including Aransas, Bee, Brooks, DeWitt, Duval, Goliad, Gonzales, Jackson, Jim Wells, Karnes, Kennedy, Kleberg, Lavaca, Live Oak, Nueces, Refugio, San Patricio, and Victoria. Most Region 5 counties are located within the Coastal Bend Council of Government (Coastal Bend-COG) geographic area. The Coastal Bend COG includes all the counties of Region 5 except Gonzales, Jackson, Lavaca, and Victoria. The region is a mix of suburban, urban, and rural areas and while it is geographically large (almost twice the size of Region 3 - Harris County) it has a relatively small population of 786,000 (about one-sixth the population size of Region 3).</p> <p>The Nueces County Hospital District, Jonny Hipp, is the Anchor for RHP 5. The RHP 5 Anchor communicates weekly with the providers sharing information on DSRIP policies, changes, and guidelines for reporting. The RHP 5 Anchor also hosts learning collaboratives, webinars, and conference calls to encourage provider participation and shared communication across the region as well as keeps current updates posted to the Anchor website.</p>	<p>RHP 5 Providers have made progress toward transformation and meeting system performance and regional goals. Through the activities of RHP 5, Providers have learned valuable lessons to transform the RHP 5 delivery system, including the use of national measure stewards. The efforts towards sustainability, alternative payment methodologies, and integration with Medicaid managed care organizations are challenging, especially for a rural RHP that does not have the volume of patients to pique interest and engagement of the managed care organizations (MCOs), nor are they in a position to take any level of financial risk. 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Many rural Providers have limited staff resources and DSRIP responsibilities are added to an existing staff person that already has a full-time workload. In DY 9, RHP 5 also experienced new performing provider staff that were not familiar with DSRIP and had a significant learning curve to understand the nuances of the DSRIP program.</p> <p>Following is a summary of the most common challenges as identified by RHP 5 Performing Providers:</p>	<p>RHP 5 Providers have made progress toward transformation and meeting system performance and regional goals. Through the activities of RHP 5, Providers have learned valuable lessons to transform the RHP 5 delivery system, including the use of national measure stewards. 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<p><b>RHP06</b></p> <p>DY9 has been a year represented by continued implementation of core activities designated in the DY7-10 RHP Plans of the Medicaid Waiver. Providers reported Category C outcomes for DY8 and Category D data for DY9 in April 2020. Providers reported Category B Patient Population by Provider data and Category A responses for DY9 in October 2020.</p> <p>All but one RHP 6 Performing Provider remained the same during this period. Nix Health closed its facilities and withdrew from DSRIP for Years 9 and 10. RHP 6 now includes 22 providers across 20 South Texas counties: Atascosa, Bandera, Bexar, Comal, Dimmit, Edwards, Frio, Gillespie, Guadalupe, Kendall, Kerr, Kinney, La Salle, McMullen, Medina, Real, Uvalde, Val Verde, and Zavala. Of the 22 providers, three are community mental health centers, one is a local health department, one is an academic physician group, and the remaining 17 are hospitals. Of the hospital providers, half are located outside of Bexar County in mostly rural communities.</p> <p>There are six community priorities for RHP 6 being addressed through DSRIP which include:</p> <ol style="list-style-type: none"> <li>1. Improve the quality and safety of care delivered in clinical settings;</li> <li>2. Prevent and/or improve the management of</li> </ol>	<p>Providers continue to learn many important lessons through the experiences of DSRIP. These lessons are communicated in conversations with the anchor, at learning collaborative events, and during semi-annual reporting.</p> <ul style="list-style-type: none"> <li>• With the new waiver model, providers have better alignment of outcome measures across our region. Knowing which measures each provider has selected and how they are progressing allows providers to collaborate and achieve success alongside others who are pursuing similar outcomes.</li> <li>• Learning Collaborative events enable providers to connect and network with other RHP providers with shared core activities and Category C measures. There is discussion and collaboration between facilities and program managers on how to best meet the program requirements. Providers can learn about other initiatives, reporting strategies, outcomes tracking, and improvement efforts. Providers have connected and identified ways to align with other stakeholders and community coalitions, including the South Texas Asthma Coalition, TMF Health Quality Institute's Care Coordination Coalition, South Texas Regional Advisory Council's South Texas Crisis Collaborative, and the Texas AIM Collaborative.</li> </ul>	<p>In DY9, the biggest challenge has been preparing for the end of DSRIP in September 2021. The earned incentives are critical to funding essential services for low income and underserved patients. Without a clear plan for sustainability, many providers are concerned they will be forced to reduce or end services that have been initiated through DSRIP. Providers have actively engaged in transition planning activities. The HHSC partner engagement webinars and newsletters have been helpful in sharing information. Providers are anxiously anticipating the HHSC proposal that is due to CMS on December 31, 2020. Providers are concerned that many of the proposals being discussed publicly are focused on Medicaid populations and not those who are uninsured. COVID-19 has been another challenge for providers throughout 2020. Providers had to pivot quickly to learn how to launch and administer telemedicine programs, engage patients in new and safe ways, communicate new rules and safety protocols, address shortages of staff and personal protective equipment, and provide acute care to COVID-positive patients. Patients had to learn how to navigate new technology and clinic procedures and often deal with loss of jobs, housing, and food during stay-at-home orders and the subsequent</p>	<p>Four representatives from RHP 6 were selected to serve on HHSC's Best Practices Workgroup, including: Carol Huber (University Health); Gordon Whiting (UT Health San Antonio); Juliana Lopez (UT Health San Antonio); and Carol Carver (Clarity Child Guidance Center). The Best Practices Workgroup completed three rounds of surveys and calls: Survey 1: Prioritizing Key Measures; Survey 2: Prioritizing Key Practices Final Results; and Survey 3: Key Measures and Practices – Stratifying MLU Population Data and Exploring Organizational Factors. The findings from this workgroup will be used by HHSC to inform the DSRIP transition proposals.</p> <p>Two representatives from RHP 6 were named to the HHSC Value Based Purchasing and Quality Improvement Advisory Committee in May 2020, including Carol Huber (University Health) and Darrick Isaac (Community First Health Plans). Public meetings were held July 1; August 25; and November 10, 2020. The committee prepared and approved a report which was submitted to the Texas legislature and HHSC Commissioner Cecile Young in November 2020. The report includes five recommendation areas to advance value-based care and payment in Texas Medicaid. The recommendations fall under the following broad questions.</p>	<p>Because RHP 6 covers a large geography, many of our communications have always been conducted via phone, email, and webinar. This structure enabled us to continue sharing pertinent information and collaborations without interruption. However, the COVID-19 pandemic prevented us from hosting our annual in-person Learning Collaborative and Stakeholder Forum. In the past, this event has allowed us to gather together more than 200 DSRIP providers and other stakeholders from across RHP 6 and Texas. We use this event to promote collaboration, engage stakeholders, and share DSRIP successes and best practices. In lieu of this in-person event, we hosted a four-part virtual series during the month of September.</p> <p>Overall, providers continued to be engaged with DSRIP activities and compliant with reporting and other requirements because the services they deliver are critical to patients; and earning the financial incentives is crucial to sustaining these healthcare organizations. COVID-19 increased demands on staff and created new opportunities for providers. Many of these were described as part of October DY9 reporting.</p> <p>Over half of RHP 6 providers noted increased use of telemedicine and telehealth services. Some providers relied on telephone visits while others</p>
<p><b>RHP07</b></p> <p>RHP 7's seven DSRIP providers completed their third year of the redesigned DSRIP program, moving from the original project-oriented reporting (Waiver 2.0) to one that is system-level and forward-looking (Waiver 3.0). After their DSRIP year ended in April 2020, providers began the final two years of the DSRIP program with DY9, continuing using standardized clinical practices, workflows, and protocols to measure and improve health outcome goals for targeted populations. The flexibility of Waiver 2.0 has allowed providers to utilize continuous process improvement methodologies utilized during Waiver 1.0 to assess progress and quickly make course corrections.</p> <p>During DY 9, DSRIP Providers, the Anchor, HHSC, and all of Texas experienced the beginning of the unprecedented and unanticipated coronavirus pandemic. DSRIP providers pivoted quickly and drastically to address patient needs as COVID-19 spread throughout RHP 7 communities. Specific DSRIP efforts, particularly preventive care, face-to-face visits, and group education efforts, were severely curtailed. CMS approved flexibility to achieve DSRIP metrics during this time was essential, and further flexibilities for DY 10 are greatly anticipated.</p> <p>Despite the impact of COVID-19, providers continued to make progress toward regional goals as laid out in the DY 9 and 10 RHP Plan Update, including achieving DSRIP outcome metrics. 90% of all Cat C measures have been 100% achieved for PY 1. Among active P4P measures that reported PY 2 achievement in April DY 9, 89% of metrics were achieved or partially achieved.</p>	<p>DSRIP providers have shown keen interest in simple, effective data visualization tools that can help communicate health outcome status to a variety of organizational and community stakeholders quickly and easily. Most providers have developed or are developing internal dashboards to monitor progress toward achievement of outcome measures and willingly share what they have developed with other providers. These tools are critical to making the organizational transition to data-driven healthcare tools from HHSC is welcome.</p> <p>The resources to invest in clinical and data analytics staff are critical to the success of value based payment initiatives.</p> <p>The Anchor continues to see value in regular opportunities for providers to exchange ideas in an informal peer-to-peer manner. These relationships have helped each provider through DSRIP challenges over the years by drawing on knowledge in the network they have developed. RHP 7 maintained these regular connections among providers virtually during the pandemic. Especially now, providers regularly and consistently</p>	<p>As stated above, providers are challenged by the lack of information about COVID 19 flexibilities for DY 10. Key provider-level operational decisions to meet DY 10 metrics are being now, and frequently strategies to keep patients and providers safe during the pandemic do not align with DSRIP metric requirements. Providers need this critical information as quickly as possible to address the risk of not meeting DSRIP metrics.</p> <p>While the return of Myers and Stauffer has brought some consistency to the DSRIP audit process, providers still struggle with communicating the specifics of their program to auditors. This makes the review process time consuming and difficult.</p> <p>While providers appreciate HHSC's efforts to improve the cost and savings analysis process, specific information about required data fields remains delayed. These specifics are important to instruct data analysts and programmers to pull the required information, which takes time and resources. The more advance notice providers have, the more successful they will be at completing analyses, especially when many resources are diverted now due to the pandemic.</p>	<p>Findings are addressed above or in the COVID-19 questions.</p> <ul style="list-style-type: none"> <li>• The DSRIP Exchange/Learning Collaborative topics changed focus on COVID-19 response and DSRIP efforts in that environment. The originally planned LC topic of directed payment programs was delayed until DY 10.</li> <li>• All Learning Collaborative meetings and Stakeholder Engagement processes were moved to virtual formats.</li> <li>• Anchor staff shifted focus to COVID-19 response, both on behalf of providers and on behalf of their home organizations. For instance, Anchor staff worked to apply for FEMA reimbursement for COVID 19 response efforts.</li> </ul> <p>How COVID-19 has impacted provider participation:</p> <p>Austin Travis County MHMR dba Integral Care Integral Care adapted to new technology by significantly expanding telehealth services in response to COVID-19 which included establishing virtual methods to support success with the DSRIP Program. Integral Care teams quickly adapted most of our care to telehealth, be it a clinic, community-based, or school-based. For adult services, the organization worked fast to transition all operations</p>	<p>How COVID-19 has impacted provider participation:</p> <p>Austin Travis County MHMR dba Integral Care Integral Care adapted to new technology by significantly expanding telehealth services in response to COVID-19 which included establishing virtual methods to support success with the DSRIP Program. 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RHP08	Regional Healthcare Partnership 8 (RHP 8) is a nine-county partnership that consists of Bell, Blanco, Burnet, Lampasas, Llano, Milam, Mills, San Saba, and Williamson counties. It is contained within Health Service Region 7 as defined by the Texas Department of State Health Services. Formed in June 2012, RHP 8 is located in Central Texas with a population of approximately 975,620, based on the most recent published US Census estimate.	As in years past, RHP 8 continues to take note and work, together and individually, to identify challenges and learn from them. As continued implementation of initiatives and core activities takes place, as well as planning and preparation for post-DSRIP transition, the region has been able to continue to move forward with providers continuing to share their experiences and knowledge with the anchor and each other.	Regional/Anchor Lessons Learned Throughout DY9, we again continue to see the lessons identified last year reiterated and be ongoing in regard to working with providers and IGRT entities to understand and manage expectations related to DSRIP transition. Those lessons continue to be that collaboration is key and will need to be expanded, as well as continuing forward with internal evaluation and small steps as the foundation to progress, especially in the face of limited information regarding the end of DSRIP and what comes next. There is benefit in active engagement in learning collaborative activities and in active engagement among Anchors across the state as well.	Challenges in a program as complex and multifaceted as the 1115 Transformation Waiver are certainly to be expected, and we have continued to experience challenges in DY9 that have also been challenges highlighted in years past including the roles and opportunities for more rural providers in value-based purchasing/alternative payment model arrangements and directed payment programs and staffing/retention among others.	Anchor/Regional Challenges As Texas moves forward with DSRIP Transition Planning and proposals for post-DSRIP programs, and continues to try and better align managed care and DSRIP initiatives, the non-hospital providers in our region carry the same concerns and continue to face challenges around their ability to participate in VBP, alternative payment models, and managed care alignment and integration. As outlined previously, this is a region-wide issue as our entire nine-county region makes up a very small percent of the state's total Medicaid population (estimated at 2.5% or less). As a result, it makes it harder to assess DSRIP impact on population health and other clinical outcome measures that may be based only on Medicaid/Medicare data. As Anchor, we struggle to assist our providers in evaluating post-	As the result of the restrictions and continued challenges facing providers, and particularly rural providers, that have been present for most of DY9, we anticipate there will be some community clinics close completely. In RHP 8, two clinics have been identified for evaluation by one provider system, and they will assess the feasibility of keeping them open versus redirecting the services elsewhere. These conversations were taking place prior to the pandemic but have been exacerbated, and determinations perhaps escalated, by the public health emergency and its impact on the healthcare system. We are aware that a change in operator will take place in one of the rural hospitals located in the region. The notification was given in DY9, but the change will not be effective until January 2021. It is uncertain, at this time, how the change in ownership from a more local system to an operator with headquarters several hours away will impact the services and operation of the facility.	The impact of the COVID-19 pandemic to RHP 8 has been broad and all encompassing, impacting every single performing provider, IGRT entity and stakeholder across every county. From the Anchor standpoint, all in-person activities and meetings planned from mid-March through the present had to be postponed, canceled, or converted to virtual platforms as there were broad travel and gathering restrictions put forth by both the state and internal to each individual organization (the anchor's university system as well as within each provider system and county). Our DY9 learning collaborative activities had to be modified, as outlined in section 1 of this report, and we were not able to perform as many cohorts and calls as we would have liked. Additionally, we had several new DSRIP coordinators start with provider facilities amid the pandemic, and, one who started two days before October reporting opened. We would normally make arrangements to conduct an in-person meeting to deliver a waiver 101 type presentation, introduce ourselves to the new DSRIP staff and reacquaint with provider leadership, and be able to answer questions while also walking through templates, sites, and also reviewing paper references and resources that can aid someone new to the waiver and to DSRIP. While we were able to transition to
RHP09	Comprised of Dallas, Denton and Kaufman counties, Regional Healthcare Partnership Nine (RHP9) performing providers include the tax-supported hospital system of Dallas County (Parkland Health & Hospital System, also serving as the anchor), a children's hospital (Children's Health), two local health departments (Dallas County HHS and Denton County HHS), a state university hospital (UT Southwestern Medical Center), a physician/dentist practice associated with a health science center (Texas A&M Health Science Center College of Dentistry), three mental health agencies (Denton County MHMR, Metrocare Services, and Lakes Regional MHMR Center), and thirteen private hospitals in the hospital systems of Baylor Scott & White Medical Centers, HCA, Methodist Healthcare, Texas Health Resources, and City Hospital at White Rock. Baylor Scott & White Carrollton withdrew from DSRIP for DY 9 & 10.	RHP9 providers continued to work towards improvements in the areas identified in the 2017 Community Needs Assessment. These include: A. Capacity and Access - More Providers and Better Health Care Coverage: Improve access to primary and specialty care in rural areas.	For ongoing governance of the RHP 9 waiver activities, we continue to collaborate with our providers through email and virtual. Stakeholder communications and in larger learning collaborative events in early DY9.  RHP 9 held the following Learning Collaborative/Stakeholder Events in DY 9:  1.November 12, 2019: RHP 9, 10 & 18 Legislative Update & RHP Plan Update Public Hearing. Hosted by RHP 9, 10 & 18 Anchors. Participants learned about the Legislative Session outcomes related to behavioral health, medical health, and ehealth activities in the state of Texas. Participants discussed DY9-10 measure bundles key strategies, challenges with these strategies, and the possible integration of some of strategies offered by HHSC for the DSRIP measure bundles. Finally, participants had the opportunity to provide stakeholder feedback during the RHP Plan Update Public Hearing session where RHP 9, 10 & 18 Anchors presented a summary of their DY 9&10 Plan Updates. The Agenda included: Mental Health in Texas after the 86th Legislature provided by the Meadows Mental Health Policy Institute, Healthcare Leaders: Legislative Update provided by the Texas	Most of the challenges for DY9 have revolved around the activities of COVID-19 pandemic response and the impact on the delivery of care and reporting of metrics identified in the next section. However, non-COVID-19 pandemic challenges identified by the providers include but are not limited to the following areas:  • The ongoing challenge of the uncertainty of clarity of the expectations for the Cost & Savings Analysis and new template for reporting in DY10. • The anxiety related to the ongoing uncertainty related to what will come next after the DSRIP portion of the 1115 waiver has ended. • The uncertainty of funding mechanisms for the non-Medicaid patients in the Low-Income Uninsured populations. There is a great deal of concern with this large group of patients especially with this related to ability to sustain programs associated with population increasing and resources being stretched thin due to the COVID-19 pandemic. • Some providers have had staffing turn over challenges due to the impending discontinuation of the DSRIP funding and uncertainty surrounding the support of the programs.	Regardless of the COVID-19 pandemic, in our communities one of the most pertinent and ongoing impacts in our efforts to improve the patient experience, improve the health of populations, and reduce the cost of healthcare are the Social Drivers of Health (SDoH). These drivers determine if patients can access available care, adhere to recommended treatments, or even afford their care. Our providers continue to strive to mitigate and assist patients and clients with these needs, some examples are listed below:  • In addition to creating efficiencies to identify patients at-risk for specific SDOH needs, a community resource directory, integrated in the E.H.R., allows clinicians to access a list of local/state entities providing individualized assistance to all patient populations. This directory continues to expand its use across the system as we align under a single E.H.R. – Baylor Scott & White Irving, Baylor Scott & White University Medical Center • Despite the ever-changing environment that developed in response to the pandemic, demand for DSRIP-supported interventions never waned. In response, the DSRIP team leveraged existing connections with community partners to connect low income and uninsured patients to community	At the request of HHSC during the summer of 2020 providers and anchors were asked to provide an update on the impact of COVID-19 response efforts in their regions. Anchors worked together to collect COVID-19 impact data from Performing Providers in their respective regions. Data was collected primarily through email via an Excel worksheet. Providers were asked to give details on the following: • Impact of COVID-19 on each of their Category C measures using specifics to describe why targets cannot be met using standard measure specifications. • Proposed accommodation(s) to address the measure impact. • Description of the impact of COVID-19 on their Cat B MLU population. • Whether they expect to meet their DY9 MLU PPP target by Sept 30, 2020. Providers were given about a week to return their data to their Anchors. Ultimately, data was collected from approximately 159 unique Performing Provider organizations across 18 regions. This data was then aggregated by the Region 3 Anchor into one Excel sheet for analysis and an executive summary document was provided. Anchors offered possible accommodations.	

<p><b>RHP10</b></p> <p>Regional Health Partnership (RHP) 10 represents nine counties in north Texas - Tarrant, Ellis, Erath, Hood, Johnson, Navarro, Parker, Somervell, and Wise - and 24 providers across the care continuum. Inclusive of the region is responsible for the implementation of 284 measures. Common threads shared across measures in the region focus on behavioral healthcare, access to primary and specialty care, chronic care management, health promotion and disease prevention and assisting patients with complex needs navigate the healthcare system.</p> <p>Regional Health Partnership (RHP) 10's implementation plan is focused on delivery reform in the following key areas as evident in the community health needs assessment:</p> <ul style="list-style-type: none"> <li>• Connect providers across the region for improved coordination and communication.</li> <li>• Empower individuals and families to manage and improve their health.</li> <li>• Provide a robust and comprehensive set of services improving the physical health, behavioral health and general well-being of Region 10 residents at an affordable cost.</li> <li>• Expand access to primary care and ambulatory care to serve more patients, particularly through medical homes offering ongoing routine care in a</li> </ul>	<p>In the time of the COVID-19 pandemic, the role of the anchor in regional governance became increasingly important to synthesize, disseminate, and coordinate information in a concise and effective manner. We've learned that in such a diverse environment in terms of geographic location, size, type and scale of providers there is no one size fits all. To better serve our providers, we continued facilitating a monthly RHP 10 call/webinar so that lead providers could respond to the RHSC Anchor Notes, engage in effective discussion and provide us valuable feedback that we share on the Anchor Calls with RHSC.</p> <p>Our regional providers look to the Anchor to be the conduit to connect them with other providers, especially in efforts to network regarding action plans at different organizations to address the COVID-19 impacts and facilitating appropriate action plans. As a result, we have provided networking opportunities and introductions across the state to engage providers in conversation regarding best practices and effective initiatives and action plans.</p> <p>The successes we have had in previous joint Learning Collaborative events with RHP 9 &amp; 18 compelled us to host our DY 9 Learning Collaborative event virtually as well. The regions</p>	<p>DY9 has been a busy year for each of our interdisciplinary bundle teams, as the goals for each metric increased to 11.75% improvement over baseline. At the beginning of DY9, operational teams performed gap analyses for each measure and bundle to assess performance at the end of DY8 and the gap that had to be closed to achieve DY9 performance rates. Each bundle team reviewed relevant processes and began developing new action plans for DY9 for each measure. In March, upon the onset of the COVID-19 pandemic, we did see a heavy impact upon our overall performance for most measures - seeing a steady decline to date. Most providers in the region have continued to see consistent decline in the performance of most measures, due to the closing/consolidation of ambulatory care sites and attention to the pandemic, as well as the appropriation of resources to address the impacts to the organization. Much of the activity across organizations was adapted to appropriately address the challenges resulting from the pandemic - low patient volumes, continuing to engage patients and development of telehealth programs, as well as protecting patients and staff from the virus.</p>	<p>Much of the future planning post DSRIP depends on accurate data and there currently exist many obstacles for effective and efficient data sharing and interoperability. Regional providers have found the structure of the Anchor and Performing Providers has worked well in allowing for collaboration, clarification of measure information, as well as reporting deadlines.</p>	<p>Challenges faced due to COVID-19 include steady decline in measure performance metrics across the region, as well as the obstacles with assuring appropriate resources were in place to continue to address the pandemic, as well as focus on the new programs needed for patients. This included the development of telehealth programs and relying heavily on this method to provide care for patients and continue to engage them in their care. Despite these efforts, the closing and consolidation of patient sites severely impacted volumes and the ability to provide in person care - for which, some measures rely on such as cancer screenings for patients. This also came with the challenge of appropriately connecting patients to resources in the community for appropriate COVID-19 care and assuring resources were in place to assist patients.</p>
<p><b>RHP11</b></p> <p>Regional Healthcare Partnership (RHP) 11 is comprised of 15 counties in West Central Texas including Brown, Callahan, Comanche, Eastland, Fisher, Haskell, Jones, Knox, Mitchell, Nolan, Palo Pinto, Shackelford, Stephens, Stonewall and Taylor. The region is primarily rural counties. 5 of which are considered frontier counties, with a population of 484,772 within 13,834 square miles. The Palo Pinto Hospital District dba Palo Pinto General Hospital, Shane Coleman, is the Anchor for RHP 11, with assistance from JoAnn Greenway, Hendrick Medical Center. Abilene, Texas, in Taylor County is the urban hub in RHP 11 with Hendrick Medical Center identified as the Major Safety Net Hospital. The system of care within RHP 11 utilizes smaller quality institutional care and outpatient services and then utilizes partnerships with the tertiary hospitals to ensure patients receive quality institutional specialty care. There are two community mental health centers in RHP 11 that provide services for behavioral health and substance use disorders. RHP 11's DSRIP projects have focused on improving access to care for primary care and behavioral health services, chronic care management, and prevention and wellness.</p>	<p>RHP 11 Providers have made progress toward transformation and meeting system performance and regional goals. Through the activities of RHP 11, Providers have learned valuable lessons to transform the RHP 11 delivery system, including the use of national measure stewards. The efforts towards sustainability, alternative payment methodologies, and integration with Medicaid managed care organizations are challenging, especially for a rural region that does not have the volume of patients to pique interest and engagement of the managed care organizations (MCOs) nor are they in a position to take any level of financial risk. RHP 11 has 9 public hospitals supported by the local tax base.</p> <p>Another RHP 11 lesson learned is the importance of patient education and outreach which is critical to success of the transformation efforts and more work is needed to change patients' learned behaviors especially for prevention and wellness. Inappropriate use of the emergency departments, and behavioral health crises.</p> <p>During DY 9, in the virtual learning collaborative meeting, time was dedicated to discussion of the DSRIP reporting requirements and DY 11 DSRIP transition opportunities.</p>	<p>While some RHP 11 Providers have experienced success in achieving their DSRIP goals this past year, transition from the project-level to system performance is not without its challenges. For example, many rural Providers have limited staff resources and DSRIP responsibilities are added to an existing staff person that already has a full-time workload. Because of the complexity of the DSRIP activities, it is difficult for staff to keep up with the constant changes and requirements of the program. Following is a summary of the most common challenges as identified by RHP 11 Performing Providers:</p> <ul style="list-style-type: none"> <li>• No consistent funding source for low income/uninsured populations</li> <li>• Significant number of non-English speaking residents</li> <li>• Patient compliance with Provider instructions</li> <li>• Staff training</li> <li>• Turnover rate of staff</li> <li>• Patient engagement</li> <li>• Shortage of clinical staff</li> <li>• Staffing and financing to modify electronic health record capabilities to align with the measurement specifications and data collection</li> <li>• The compliance monitoring audits included data that was not a part of the measure steward</li> </ul>	<p>RHP 11 has made significant strides in moving towards regional health care transformation by implementing evidence-based strategies to empower patients to make lifestyle changes to stay healthy. RHP 11 is very interested in the potential DSRIP transition opportunities beginning in DY 11 and are offering to participate in a collaborative partnership with HHSC to address the unique access and financial health of the rural health care delivery system.</p>	<p>Most RHP 11 providers reported COVID-19 had an impact on their DY 9 activities and projects. Declines in patient volume is a common problem, particularly during the early months when the initial stay-at-home orders discouraged or prevented patients from seeking preventative or non-emergency medical care. The decline in patients reduced providers' ability to provide DSRIP program services such as preventative care, wellness checks, chronic care management activities, and behavioral health services. Several providers responded to the challenges by implementing telemedicine/telehealth services. While this was an effective option for some services, the transition was difficult for some patients and is not well-suited for some activities. For example, providers were not able to conduct some screening services, such as BMI, foot exams, and eye exams because they are required face-to-face encounters. One provider also reported that the pandemic caused concern among pregnant women on keeping their prenatal visits versus exposure to COVID-19. This concern carried over to the post-partum visits as well. Telemedicine/telehealth also was not feasible for all patients. Some do not have access to internet services/broadband or did not have the necessary</p>



Attachment W  
DSRP Reporting Data  
3/1/21

RHP12	Regional Implementation of the RHP Plan RHP 12 is comprised of both urban and rural areas. The RHP 12 Urban region consists of 3 counties: Lubbock, Potter, and Randall counties. The urban region consists of 2,715 square miles with a population density of 198.8 residents per square mile. The rural portion of the region consists of 42,955 square miles with a population density of 8.74 residents per square mile. The region is anchored by the only Urban Public Hospital and Level I Trauma Center in our region, University Medical Center (UMC) in Lubbock, TX. Region 12 dropped from 37 performing Providers to 36 during DY7. One of our urban hospitals combined with their Physician group due to the DY7-8 program changes. We still have a couple of UIC only providers as well. The Performing Providers in our region selected 14 hospital and physician practices measure bundles as well as 12 measures from the UIC Care Community Mental Health Center Department measures and 4 measures from the UIC Care Local Health plan. Moving forward into DY9-10, we had 2 Performing Providers, 1 urban hospital and 1 rural hospital, opt out of DSRIP participation, bringing us down to 34 performing providers in our DY9-10 RHP plan. These 34 performing providers have chosen to continue with measures from 14 hospital and physician practices measure bundles, 12 unique Community Mental Health Center measures, and 4 measures from the UIC Care Local Health Department measures. For DY9-10, the 34 performing providers in our region are categorized by the provider types below: Rural Hospitals – 1 Providers	This past demonstration year, our biggest lesson learned from a regional governance perspective was the importance of steadfastness in the face of uncertainty. Throughout the year, we as a region worked continually to serve our patients, ensure accurate data collection despite changing patient environments, and complete our DSRIP reporting requirements despite not having certainty of what, if any, COVID allowances would be given or what the future of the program beyond DY10 would look like. As an anchor team, we worked to keep our providers as informed as possible as new information was released. Throughout the demonstration year, we worked to guide our providers through reporting, TA flags, audit processes, and multiple surveys amidst shifting priorities brought on by a global pandemic. 2B-Lessons Learned- Learning Collaborative/Continuous Quality Improvement Activities Our learning collaborative format changed this year due to safety concerns, as well as travel and in-person meeting restrictions. We offered a series of four virtual events, each lasting one hour. In preparation for these events, we ascertained the	This year frequent and close deadlines have remained a challenge. While Plan Updates were not due this year, the combination of reporting, TA flags, Myers and Stauffer auditing deadlines, and frequent surveys with little turn-around time made it seem to providers that there was always something due. Provider frustrations were high as they felt constant pressure to submit information while struggling to deal with the stress and demands of COVID-19. This year overcoming uncertainty about DSRIP transition and future funding sources has continued to be a challenge. Providers are working to ensure sustainability for the programs, additional staff, and quality procedures that have been put in place over the course of DSRIP. Providers are hopeful for governing decisions that will allow them to continue providing much needed care and services to both the Medicaid and uninsured populations. 3B-Challenges at the Provider/Project Level RHP 12 providers faced challenges in several areas this year, including staffing, data collection, and telehealth implementation. Staffing	The waiver definitely has brought about extensive and much-needed collaboration as hospitals, physician practices, behavioral health centers, health departments, and their respective communities have come together to provide excellence in healthcare throughout the region. Also, the waiver has created opportunities to highlight the hard work and dedication that physicians and staff display on a daily basis. Learning collaboratives and workshops build those forums. Moving into DY9, it quickly became evident that we, as a region, had to be able to adapt, plan, and evolve. The anchor team responded to the needs of the performing providers by hosting various sessions such as the October DY9 Reporting Session, Costs and Savings webinar, and the DSRIP 101 WebEx Sessions. Each of these sessions offered valuable information to the region and addressed similar concerns/issues experienced by providers. In general, collaboration has been the key to success throughout the region. Providing providers with these collaborative opportunities allow them to share their problem-solving initiatives with each other. This was particularly valuable as far as data collection, report writing, and especially	COVID-19 led to a variety of changes to our region's healthcare systems, which limited service capacity. Clinicians were redeployed, many employees were moved to working from home, and in some cases, staff was furloughed. Hiring freezes were enacted, and some facilities were not able to replace needed staff. Additionally, our region had staff shortages due to employees who were ill and/or having to quarantine. Clinic hours were decreased (some clinics were even closed), some appointment slots were reduced. ED volume and inpatient admissions were down due to forced volume reductions and increased push for more safety measures. When clinic appointments were available, patients were hesitant to risk COVID exposure by coming in for well visits, chronic condition care, cancer screenings, lab work, vaccines, and low-acuity ambulatory conditions. Providers worked to establish safety measures and trust with patients so people were willing to come back into clinics, and as a result, our region's providers have slowly started to see growth towards normal clinic volume. Providers also worked diligently to establish effective telehealth services, which was discussed
RHP13	RHP 13 encompasses the Heart of Texas region and areas north and west of it. This region includes Coke, Coleman, Concho, Crockett, Irion, Kimble, Mason, McCulloch, Menard, Pecos, Reagan, Runnels, Schleicher, Sterling, Sutton, Terrell, and Tom Green counties. These counties continue to be rural and frontier areas in Texas. Adult diabetes and adult obesity remained the highest-ranking needs in the CNA that was conducted in previous years. Access to mental health care emerged as a higher priority need than access to primary care, which was reflected in the prioritization as part of the CNA. The Rural Health measure bundles were selected by the majority of providers in RHP13 and continue to make impact on the identified needs. RHP13 Anchor Team hosted conference calls on November 26, 2019 and April 21, 2020. There was much discussion regarding the DY9 and DY10 plan update, healthcare transformation, improvements and innovation as we continue to progress through DSRIP. There have not been any updates to the	Working with the HHSC Waiver team, leaders involved with the waiver understand more of the delivery transformation ideas and goals, but many providers and staff on the front lines don't grasp the larger goals related to delivery transformation as they are often in the day-to-day activities where old models are being utilized. Leaders seek to educate and empower providers and staff through better and more effective communication tools. In addition, it is apparent to understand the complexities of the measure bundle specifications at the front line level to ensure communication and documentation are clear at the provider level.	The complexity and administrative burden of the Category C measure bundles continues to cause confusion and conflicting interpretations of clinical outcomes measures. We continue to be diligent with understanding the specifications, and develop consistency in our reports. This has become more apparent for some providers that have been through the MSCL audit review. Partnerships and innovation need to be further fostered, particularly in rural regions. Whether that is through data sharing or regional projects, it is imperative to continue fostering partnerships and collaborations in rural regions.	N/A	COVID-19 has impacted the ability to host in-person meetings, events and activities for learning collaboratives, as well as education outreach in communities. In addition, COVID-19 has put significant strain on performing providers in RHP13 due to lower volumes, staffing resources, limitations on services provided, etc. The continued impact of COVID-19 is unknown at this time, but we believe there will be a lasting impact to rural healthcare and rural communities. Our goal is to continue efforts under our selected measure bundles to improve the health outcomes for those we serve.

<p><b>RHP14</b></p> <p>In collaboration with DSRIP providers and stakeholders, the anchor developed and obtained HHSC approval for the DY9-10 RHP 14 DSRIP Plan. For the DY9-10 period, RHP 14 DSRIP performing providers declined from 10 to 8, following Martin County Hospital District and Winkler County Hospital District's withdrawal from the DSRIP Program. RHP 14 providers largely continued prior year's measure bundles and core activities in support of the RHP plan and community needs assessment, with a particular emphasis on expanding access to primary care and specialty care, improving maternal care outcomes, promoting health education and wellness, and increasing care coordination and management for patients with chronic diseases.</p> <p>During DY9, the RHP 14 anchor held regular conference calls with DSRIP providers and stakeholders on the DY9-10 plan, DSRIP reporting, and HHSC's proposed COVID-19 accommodation proposal. The anchor solicited and obtained feedback on RHP plan development and COVID-19 impacts. The RHP 14 anchor also hosted an annual stakeholder meeting event in September 2020, which brought together providers and other stakeholders to discuss topics of interest and concern for the Region.</p>	<p>On September 17, 2020, the RHP 14 Anchor hosted a stakeholder meeting with regional providers and stakeholders. The main topics of discussion included RHP 14 April DY9 reporting results, COVID-19 Pandemic briefing, compliance monitoring, and DSRIP planning for DSRIP transition. Two smaller providers decided to opt out of DY9-10 DSRIP. Despite challenges presented by COVID-19 and uncertainty surrounding the DSRIP Transition, RHP 14 providers remain committed to continue DSRIP improvements in DY9-10.</p>	<p>At the RHP system level, a common challenge that DSRIP performing providers faced is coordinating resource investments to continuously improve DSRIP performance while at the same time planning for DSRIP transition. Two smaller providers decided to opt out of DY9-10 DSRIP. Despite challenges presented by COVID-19 and uncertainty surrounding the DSRIP Transition, RHP 14 providers remain committed to continue DSRIP improvements in DY9-10.</p>	<p>Providers remain concerned about the uncertainty of the Waiver renewal, DSRIP Transition, and ongoing COVID-19 impacts on provider systems and DSRIP. With respect to the DSRIP transition, providers remain especially concerned about HHSC's apparent plan to continue quality initiatives through Medicaid MCOs. DSRIP providers are concerned about how the uninsured will fit into a post-DSRIP quality initiative and how to improve collaboration with MCOs to ensure a successful program.</p> <p>Providers experienced several challenges:</p> <ul style="list-style-type: none"><li>Providers suspended non-emergent services, reduced hours, or closed clinics and facilities to comply with Stay-at-Home orders and CDC guidelines to prevent the spread of COVID-19. These service disruptions resulted in patients delaying care presenting in more dire health status. This has contributed to higher volumes of admissions and readmissions, longer lengths of stay and overall negative health outcomes.</li><li>Providers have offered telehealth services as an alternative to patients seeking face-to-face care. However, some MLU and/or rural patients do not have the resources to take advantage of telehealth services. In addition, some services required to meet DSRIP metrics cannot be conducted remotely. For example, performing foot exams or HbA1C.</li></ul>	<p>The COVID-19 pandemic has not directly impacted RHP 14 activities conducted in DY9. The Anchor held regular conference call meetings with stakeholders and hosted a virtual annual stakeholder event in September. All 8 DSRIP providers in the region participated in DSRIP during DY9, despite disruptions to operations, workforce, and finances caused by the pandemic.</p> <p>Providers experienced several challenges:</p> <ul style="list-style-type: none"><li>Providers suspended non-emergent services, reduced hours, or closed clinics and facilities to comply with Stay-at-Home orders and CDC guidelines to prevent the spread of COVID-19. These service disruptions resulted in patients delaying care presenting in more dire health status. This has contributed to higher volumes of admissions and readmissions, longer lengths of stay and overall negative health outcomes.</li><li>Providers have offered telehealth services as an alternative to patients seeking face-to-face care. However, some MLU and/or rural patients do not have the resources to take advantage of telehealth services. In addition, some services required to meet DSRIP metrics cannot be conducted remotely. For example, performing foot exams or HbA1C.</li></ul>
<p><b>RHP15</b></p> <p>The RHP 15 continues to implement the regional plan during DY9 (Oct 2019 thru Sep 2020). The metrics are aligned with the community health needs assessment, and are focused in the five identified priority areas in our region: 1. Promote Healthy eating and active living; 2. Improve Mental Health and Treatment; 3. Reduce Tobacco and alcohol use and drug abuse; 4. Improve Sexual Health; 5. Improve Health Care Access.</p> <p>Providers in the region have been struggling this year in implementing their bundle metrics due to the effects of the pandemic. Throughout the year, RHP 15 facilitated participating providers in presenting their core activities, their progress and their challenges on Category C metrics. This information was presented to the entire region during the regularly scheduled monthly RHP meetings. As a result of these presentations several data sharing agreements were established between Texas Tech University Medical Center and the El Paso Health Department. A Regional Learning Collaborative was scheduled for July 2020 but was cancelled due to the COVID restrictions in gatherings. The region also felt strongly that an online platform would not benefit the collaborative's efforts and voted to not host an online Learning</p>	<p>From a regional governance perspective, RHP 15 has a solid team representing each of the seven participating providers. There has been some turnover in DSRIP leadership at two of the provider hospitals. The RHP 15 Anchor provided training and education to the new DSRIP leaders hired. Designated representatives continue to attend monthly meetings chaired by the Anchor (UMC) and collaborate well with regard to the DSRIP initiatives. This synergy has resulted in the ability of the DSRIP providers to effectively share interventions, innovations, challenges and data. The Nurse to Nurse handoff project (standardizing Nurse-to-Nurse handoffs) continue in the coming year and will serve as a continuous quality improvement involving an RHP 15 patient's transitions and continuity of care. The region has also voiced a desire to further explore tele-medicine and tele-health applications in our region. This will be explored further during the 2021 Learning Collaborative.</p>	<p>Examining the feedback from RHP 15 providers during DY9 monthly meetings, several common challenges arise: 1. Concerns for the future of DSRIP initiatives post-DY10. 2. Confusion in the understanding and interpretation of the state's "Transition Plan". 3. Concern for the future of funding for LIU patient care services after DSRIP has ended.</p>	<p>The are no additional pertinent findings from RHP 15 during DY9.</p>	<p>As discussed previously, COVID-19 impacted the annual Learning Collaborative event that RHP 15 usually hosts in the summer. The planning committee decided to cancel the event this year. RHP 15 has also noticed that attendance in the monthly (online) meetings has dropped significantly due to COVID-19. This may be due to the fact that there are many online meetings and providers are forced to make decisions at which meetings to participate. Finally, there is a concern among those providers who are pursuing primary care metrics that with the transition to telehealth/telemedicine modalities that many metrics (especially those that had been historically successful) are now not being met.</p>

<p><b>RHP 16</b></p> <p>1) RHP 16 began DY9 with monthly meetings between performing providers in order to discuss issues related to reporting and achievement of selected performance measures. Performing providers in RHP 16 include Corvett Health, Hamilton Healthcare System, Limestone Medical Center, Baylor Scott &amp; White Hillcrest, Providence Health Center, Goodall Wilcher Hospital, and Heart of Texas (HOT) MHR. This represents 2 urban, tertiary healthcare centers, 4 rural hospitals and associated clinics and 1 local mental health authority. Using the community needs assessment, providers selected measures that would impact current challenges related to community health and the existing healthcare delivery model. During DY9, every performing provider made adjustments to their delivery model due to the COVID-19 pandemic. Services were postponed and many rural providers, changing to a telehealth platform was slow and not used to its full extent due to limited or no internet services in their area. Providers in the urban areas were able to transition quickly and transition their patients to telemedicine. 2) RHP 16 held monthly telephone calls and one annual learning collaborative that also included HHSC to talk about the upcoming Cost&amp;Savings</p>	<p>During DY9, we conducted monthly calls with regional performing providers and one annual meeting that also included HHSC. During those meetings we discussed the following: 1) more efficient use of hospital space for potential increase in patients, 2) ICU physician support from urban hospitals, 3) COVID-19 testing standards, 4) challenges related to physical assessments during telehealth visit (BP, BMI, etc), 5) promote the inclusion of telehealth visits as part of Category B reporting, 6) Cost &amp; Savings education and preparation for 2021 including core activity selection and inclusion of data points such as start up costs and operating costs - this will present some challenges for providers who are using start up costs related to core activities that began 2 - 3 years ago such as new staff and turnover in certain departments. RHP 16 also hosted a series of meetings related to DSRIP Transition and opportunities for partnerships. The first focus area was palliative and specialty care programs. These were projects in DY1 - DY6 but they did not continue in DSRIP 2.0. Providers agreed that there is opportunity to share resources and expand (or restart) programs for the benefit of our patients and care continuity. We also discussed sustainability and how we can simplify quality programs during</p>	<p>Significant challenges: 1) COVID-19 impact on patients with chronic medical conditions. Many of these patients postponed routine exams and testing that have made it challenging for providers to achieve their 2020 measurement goals. 2) Most regional meetings were conducted by zoom. Face to face interaction is the preferred method for in-depth discussions around potential partnerships between regional performing providers. We were fortunate to have several productive calls during the latter part of DY9 to talk about DSRIP transition.</p>	<p>The regional leadership structure and learning collaborative requirements are essential to the continuation of the work we have accomplished as individual providers and as a group. Sharing of information and best practices would not exist without a regional focus as it relates to quality measures and projects that are designed to improve access to care and quality. Working together allows us to create partnerships and share vital data that overall increases our ability to meet the challenges of the triple aim. DSRIP Transition is a major concern for all providers especially as we near the end of DSRIP 2.0. We anxiously await decisions and further instructions on how we will continue the work that has been achieved for the thousands of patients in RHP 16.</p>	<p>1) Major activities that were impacted were few although face to face meetings were eliminated. We hosted our monthly and annual meetings by telephone and zoom. We also attended several learning collaboratives from other regions that were held by zoom as well. 2) Provider participation has remained steady although several smaller hospitals redirected staff to assist with COVID-19 preparation. Quality measures will be difficult to achieve due to limited resources for most providers. 3) Challenges between providers, as mentioned above, mainly concerned connectivity in urban areas vs rural areas for telehealth services. Many providers in rural areas experience dropped calls or poor video transmission that was not conducive to a meaningful physical/ patient visit. Staffing was limited in rural areas as many nurses and support staff were reassigned to other areas of the hospital and/or clinics for parking lot visits (patients were seen in their vehicles) or sent to triage in the emergency department. Most providers maintained their quality protocols in the clinic and hospital but due to the drastic and immediate change in the way patients were being seen (or not seen at all), many of the required elements within a quality measure may not have been met.</p>
<p><b>RHP 17</b></p> <p>Regional Healthcare Partnership 17 (RHP 17) consists of Brazos, Burleson, Grimes, Leon, Madison, Montgomery, Robertson, Walker and Washington Counties. The regional population was approximately 845,000 people spread across the nine counties, and we anticipate the 2020 census will show increased growth and additional need for healthcare access and services made possible by DSRIP. While the region overall is a smaller, Tier 4, rural region in Texas, the RHP does include two larger urban areas within its borders (Bryan/College Station in Brazos County and Conroe/The Woodlands area in Montgomery County, where over half the region's population resides).</p> <p>The RHP 17 Anchor Team utilizes multiple methods of communication in an effort to execute the RHP Plan, as well as to continually promote stakeholder engagement and work to ensure that all key stakeholders, particularly IGT Entities and Performing Providers, are well informed and up to date on the latest developments surrounding the Texas 1115 Medicaid Quality and Transformation Waiver. While stated in past report that open communication with the RHP is important, there has been a greater sense of urgency and need to</p>	<p>As in years past, RHP 17 continues to take note and work, together and individually, to identify challenges and learn from them. As continued implementation of initiatives and core activities takes place, as well as planning and preparation for post-DSRIP transition, the region has been able to continue to move forward with providers continuing to share their experiences and knowledge with the anchor and each other.</p> <p>Regional/Anchor Lessons Learned</p> <p>Throughout DY9, we again continue to see the lessons identified last year reiterated and be ongoing in regard to working with providers and IGT entities to understand and manage expectations related to DSRIP transition. Those lessons continue to be that collaboration is key and will need to be expanded, as well as continuing forward with internal evaluation and small steps as the foundation to progress, especially in the face of limited information regarding the end of DSRIP and what comes next. There is benefit in active engagement in learning collaborative activities and in active engagement among Anchors across the state as well.</p> <p>We have continued building on the lessons around</p>	<p>Challenges in a program as complex and multifaceted as the 1115 Transformation Waiver are certainly to be expected, and we have continued to experience challenges in DY9 that have also been challenges highlighted in years past including the roles and opportunities for more rural providers in value-based purchasing/alternative payment model arrangements and directed payment programs and staffing/retention among others.</p> <p>Anchor/Regional Challenges</p> <p>As Texas moves forward with DSRIP Transition Planning and proposals for post-DSRIP programs, and continues to try and better align managed care and DSRIP initiatives, the non-hospital providers in our region carry the same concerns and continue to face challenges around their ability to participate in VBP, alternative payment models, and managed care alignment and integration. As outlined previously, this is a region-wide issue as our entire state's total Medicaid population. As a result, it makes it harder to assess DSRIP impact on population health and other clinical outcome measures that may be based only on Medicaid/Medicare data. As Anchor, we struggle to assist our providers in evaluating post-DSRIP</p>	<p>As the result of the restrictions and continued challenges facing providers, and particularly rural providers, that have been present for most of DY9, we anticipate there will be some community clinics close completely. Some of our provider organizations have indicated they are having internal review and discussion regarding the clinics they have in several rural communities and whether it is feasible to keep those clinics open versus redirecting the services elsewhere. These conversations were taking place prior to the pandemic but have been exacerbated, and determinations perhaps escalated, by the health emergency. During DY9, we had a change in ownership of two different hospitals in the region finalized by two different health systems; one sale occurred in Brazos County and the other in Walker County. With regard to regional participation and DSRIP activities, both transitions have gone smoothly, and the hospitals continue to provide services and implement their DSRIP initiatives. Specific to the communities served, the hospitals reported that the new partnerships have allowed greater access to resources and strengthened their standing in the community as part of their new hospital networks.</p>	<p>The impact of the COVID-19 pandemic to RHP 17 has been broad and all encompassing, impacting every single performing provider, IGT entity and stakeholder across every county. From the Anchor standpoint, all in-person activities and meetings planned from mid-March through the present had to be postponed, canceled, or converted to virtual platforms as there were broad travel and gathering restrictions put forth by both the state and internal to each individual organization (the anchor's university system as well as within each provider system and county). Our DY9 learning collaborative activities had to be modified, as outlined in section 1 of this report, and we were not able to perform as many cohorts and calls as we would have liked. Additionally, we had several new DSRIP coordinators start with provider facilities amid the pandemic, and, one who started two days before October reporting opened. We would normally make arrangements to conduct an in-person meeting to deliver a waiver 101 type presentation, introduce ourselves to the new DSRIP staff and reacquaint with provider leadership, and be able to answer questions while also walking through templates, sites, and also reviewing paper references and resources that can aid someone new to the waiver and to DSRIP. While we were able to transition to</p>

Attachment W  
DSRIP Reporting Data  
3/7/21

<p><b>RHP18</b> RHP18 represents three counties in North Texas, Collin County (the Anchor Entity), Grayson County, and Rockwall County. The Collin County government has invested in the Medicaid Waiver initiatives since 2011. Performing in the Anchor leadership role, Collin County has inspired other IGT entities to support the DSRIP initiatives. The population in this geo-political area has grown by 30.7% since July, 2011 when the first DSRIP CNA was completed. Medicaid populations have increased and reports are that the uninsured numbers have also grown. Unfortunately population numbers are difficult to obtain at the county level. There are five participating DSRIP providers that still report through this RHP. These are Texoma Community Center, Texoma Medical Center, Rockwall County Helping Hands Clinic, LifePath Systems (the Collin County Community Center), Baylor Scott &amp; White Centennial Hospital (the Douglass Clinic), and Brock L. Pierce, MD, with two OB/GYN clinics in Collin County. Three providers who have continued services in this RHP but whose performance is unknown to us, have been reporting through RHP9 for the past two years. Those are Lakes Regional MHR in Rockwall, Children's Health, and UT Southwestern.</p> <p>All five RHP18 reporting providers have met or</p>	<p>Some unique trends are emerging in Collin and Grayson Counties that may impact healthcare services post-DSRIP. FQHCs are expanding in Collin County. Both counties are seeing an increase of populations who are uninsured, and who are approaching but not reaching the Medicaid eligibility threshold. In RHP18, the county and city governments have learned more about the importance of encouraging local providers to address and monitor the growing needs. We have learned that while the counties health departments and government leaders understand the value of cooperation across healthcare systems, it is not necessarily within their span of influence to cause it to occur.</p> <p>In RHP18, we have convened DSRIP providers around care coordination policies and procedures, and communicated with organizations representing the larger system of care, such as the DFW Hospital Council. Unfortunately there are few incentives to create economic win-win scenarios in the healthcare arena.</p> <p>The Waiver program initially explored strategies for improving care coordination through data sharing and inter-organizational communications, but the momentum toward a broad healthcare consortium model has slowed. Thus a lesson learned is that</p>	<p>In DY8, Collin and Rockwall Counties provided IGT to add participating providers in the DSRIP program, reaching out to additional underserved populations, including maternal health, and primary care. When the DSRIP program changed to measure bundles, primary care per se, lost its position in the hierarchy of program options, with a preference given to specific conditions, and "value points." A focus on points shifted the attention to discrete populations. Two of the primary care clinics in RHP18 opted for the Diabetes Care measure bundle, and the other opted for Cancer Screening. While certainly these are of vital importance, we did lose the ability to monitor access to, and utilization of the basic health services that prevent avoidable ED and inpatient use. We also lost opportunities to formally link hospital data with community based care data. We began the DSRIP program with enthusiasm for collaboration across provider types that might create a new perspective on care coordination and hospital-community partnerships. We formed an Executive Committee, and several working groups to develop and pursue feasible innovative ideas for local healthcare delivery system transformation. Without fiscal and other incentives, or infrastructure for data sharing and care coordination, or flexibility in the use of DSRIP funds</p>	<p>We have made several efforts to connect providers with MCOs to discuss APMs. Small providers are waiting until the state directs a program that would allow their participation in these models. Providers continue to rely on the Anchor team for support, clarification, and reporting. Strategic planning, as well as audit process reviews. Collaborating with RHPs 9 and 10 for Learning Collaboratives and other communications networking across providers had been beneficial.</p>	<p>During DY9, major activities were only conducted between October 2019 and March 1, 2020 due to the necessity of social distancing, shutting down in-person visits to the provider offices by the Anchor team, and calling a halt to routine RHP-wide in-person meetings. It has been a serious challenge to bring together a diverse group of 5 providers, having 8 providers was far better for identifying common ground and sharing best practices even through the PDSA process. Collaborating with RHPs 9 and 10 enables us to open the door for our providers to a wider range of thoughts, ideas, and activities, and to enrich the conversations about healthcare services/systems transformation. Sometimes evolutionary baby steps are harder on a system, than a full-on rapid change through a revolution, with expectations for exponential improvements - improving health, improving systems management, increasing collaboration, and implementing fiscal parsimony.</p>
<p><b>RHP19</b> RHP 19 continues to serve the providers within our geographic boundaries and beyond in order to pursue delivery system changes and networks that will provide a sustainable solution for rural Texas. Rural Texas continues to have a larger percentage of low income and uninsured persons as well as a larger administration and financial burden when treating Medicaid patients. As DSRIP comes to a close next year, RHP 19 has sought to prepare the region and our providers for DSRIP transition or a state directed payment program that will be sustainable and quality based. We haven't been able to conduct in-person meetings, but we still work to facilitate messages and education amongst providers and Texas Medicaid.</p> <p>Clinics remain open, and we believe that COVID-19 has brought telemedicine to the forefront. Our community and regional leaders recognize the benefit to patients to have access to their providers accessible, whether in person or virtually. We have begun to discuss a collaborative network where we can plan and better ensure patients have access to high quality care at home. RHP 19 is supportive of a quality based supplemental program that will transition us from DSRIP to an innovative payment structure that shares risk while sustaining rural providers.</p>	<p>RHP 19 recognizes the importance of value-based reimbursement and has learned through DYs 7 and 8 that quality goals can be achieved in rural settings. We have learned that by sharing ideas and best practices through our Learning Collaboratives, we can highlight the providers that have been successful and help each other achieve goals. However, success does not come without cost. Best practices and goal achievement have been successful because of increases in staffing, electronic tracking and other methods that were not in place prior to DSRIP. As for governance, we continue to assist all of the RHP 19 providers with reporting, relay information from HHSC, provide them with guidance and updates on DSRIP transition, and assist with implementing measures that will help them be successful.</p> <p>Our goal as the anchor for RHP 19 is to continue to focus on access to high quality primary and preventive care achievement of provider goals.</p>	<p>One provider in RHP 19 withdrew from the DSRIP program during DSRIP 1.0. Another withdrew in DY8 due to the administrative burden of capturing information and reporting Category C outweighing the financial gain. We continue to look for ways to include providers that have previously withdrawn but are now ready to engage, and for ways to make financial incentives rewarding enough to keep providers motivated to implement and report quality measures.</p>	<p>RHP 19 has endeavored to be a thought and change leader by identifying best practices, sharing ideas, and demonstrating methods that can be standardized in rural areas all over Texas. We have worked to improve access to both primary and specialty care for rural Texans while preparing our providers for the end of DSRIP and beyond. Continuing to utilize or implement best practices will require providers to incur additional costs, so we look forward to educating providers about post-DSRIP programs so that we can effectively measure the high quality care that we provide and capitalize on any future incentive payments.</p>	<p>COVID-19 has been a challenge both at the anchor and provider level. Our DY9 Learning Collaborative was held virtually. It was well attended, but interaction was not as high as in-person LCs of the past. Many providers implemented telehealth and are thankful for the recognition by CMS that telehealth is an effective, justifiable and necessary service that warrants reimbursement at a higher level than pre-pandemic payments. However, many of our rural providers are discouraged by the challenges that come with reporting DSRIP measures with or without telehealth visits. Whether providers are reporting on rural measures or more complex measures, the frustration level is similar. Providers have had to put DSRIP measures on the back burner in order to deal with the COVID-19 pandemic. Staffing levels have had to be increased in order to screen patients in clinics and staff COVID units in addition to med/surg units. As COVID-19 began to infiltrate staff, personnel from every department were reassigned to fill holes and make sure patients were cared for, whether through front-door screening, answering telephones, cleaning, calling hospitals to try to find open beds for transfers, or direct patient care. The stress on the staff is great, so pressuring them to monitor DSRIP measures has just not been at the top of the "to do"</p>



Attachment W  
DSRIP Reporting Data  
3/7/21

<p><b>RHP20</b> As with health providers around the country, the COVID-19 pandemic has had a big impact on Region 20. While our providers were able to transition some of their services from in-person to online or telephone services, this was not possible for all of the services provided. The silver lining of this pandemic is that it has further strengthened the collaboration between our providers and other organizations in our community. Our providers have continued working on project sustainability but with the already high number of low income/uninsured in our community coupled with the growing number of persons being unemployed and ineligible for health care coverage, the number of people needing services continues to increase while funding sources remain scarce. Our RHP website has been updated to reflect changes in leadership with several of our performing providers and any pertinent information.</p>	<p>DSRIP providers have continued to collaborate and provide referrals to other DSRIP providers for services that they may qualify for that the original provider does not provide. Providers have also continued to expand how they deliver services due to COVID-19 restrictions while also looking into alternative funding sources to offset the uncompensated care that they currently provide. Collaboration between providers has included referrals to medical homes/primary care providers for patients seen at emergency rooms or urgent care clinics so that they are able to obtain ongoing primary care services, behavioral health services, disease self-management classes, etc. especially if they are at higher risk of complications if exposed to COVID-19.</p>	<p>The biggest challenge with providers continues to be the potential sustainability for their DSRIP programs without the supplemental funding they were receiving as their population is mostly uninsured and low-income. While there are "low-cost" insurance options available for some of our population, the monthly premiums, high deductibles, and high copays in essence make them out of reach for most of our low income residents. While there was a reduction a few years ago from county residents with no legal status obtaining medical care, we are still working with local agencies to educate residents on their rights to medical services as their legal residency, or lack thereof, does not affect their ability to access care.</p>	<p>The majority of our region's population is considered low-income uninsured and/or Medicaid eligible and we are designated as a Health Professional Shortage Areas (HPSAs) so it is even more difficult for those residents with no medical insurance or coverage to be able to afford and pay for medical care. A lot of these residents rely on health fairs, traveling health care teams, and medical mission clinics to obtain primary care to treat chronic medical conditions such as hypertension, diabetes, and mental health issues. Unfortunately, due to COVID restrictions, most, if not all, of these health events were cancelled or postponed indefinitely. Additionally, persons with health conditions or illnesses that put them at higher risk of developing complications from COVID-19 have postponed attending their medical appointments for fear of contracting the COVID virus or exposing their family members to it. There is a still a large need for services for those residents who are uninsured, under-insured, and Medicaid recipients that continue to benefit from DSRIP programs. The lack of medical providers, both primary and specialty care, is still a major factor in access to affordable care. The HRSA Claims Reimbursement program for uninsured has helped some providers who would otherwise not be able to</p>	<p>COVID-19 has had a huge impact on our region as it was already classified as a medically underserved area. COVID-19 has further limited the availability of access to healthcare not simply because there are not enough providers to provide care to our population but many people have stopped or severely limited their visits to medical providers due to a fear of contracting COVID since they are aware of how our local hospitals are at capacity with COVID and critically ill patients. The performing providers in RHP20 consist of two hospitals, the local health department, and the local mental health authority - all of which were extremely hard hit with COVID. As of December 11, 2020, Laredo hospitals had the highest hospitalization rates in the State of Texas with a 31.6% COVID-19 hospitalization rate. While our local hospitals have been able to receive assistance from state strike teams that provide clinical staffing to support for critically ill patients, many in our community continue to have problems accessing medical care for non-COVID related illnesses.</p>
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## DY9 DSRIP Reporting Summary

RHP 01					
April Reporting Period	# of milestones/ metrics eligible to report	# of milestones/ metrics reported as achieved	# of milestones/ metrics approved	Payment amount approved	
Cat B - DY8 CF	3	3	3	\$1,914,333	
Cat C - DY7 CF	60	54	44	\$6,921,398	
Cat C - DY8	361	349	339	\$79,194,390	
Cat C - DY9	2	2	2	\$234,463	
Cat D - DY9	112	107	107	\$16,454,819	
October Reporting Period					
Cat B - DY9	20	20	20	\$11,044,255	
Cat C - DY8	12	0	0	\$0	
Cat C - DY9	0	0	0	\$0	
Cat D - DY9	5	5	5	\$111,563	
Totals	558	540	520	\$115,875,221	

RHP 03					
April Reporting Period	# of milestones/ metrics eligible to report	# of milestones/ metrics reported as achieved	# of milestones/ metrics approved	Payment amount approved	
Cat B - DY8 CF	1	1	1	\$396,218	
Cat C - DY7 CF	152	146	96	\$33,720,222	
Cat C - DY8	762	688	620	\$371,082,785	
Cat C - DY9	17	11	11	\$1,373,239	
Cat D - DY9	147	125	124	\$75,556,829	
October Reporting Period					
Cat B - DY9	25	23	23	\$59,555,663	
Cat C - DY8	74	74	66	\$48,594,596	
Cat C - DY9	6	6	6	\$1,645,312	
Cat D - DY9	22	22	23	\$14,457,842	
Totals	1104	1096	970	\$606,382,706	

RHP 05					
April Reporting Period	# of milestones/ metrics eligible to report	# of milestones/ metrics reported as achieved	# of milestones/ metrics approved	Payment amount approved	
Cat B - DY8 CF	0	0	0	\$0	
Cat C - DY7 CF	59	58	45	\$14,118,424	
Cat C - DY8	305	301	278	\$123,680,123	
Cat C - DY9	4	4	4	\$557,794	
Cat D - DY9	74	74	74	\$27,876,437	
October Reporting Period					
Cat B - DY9	10	10	10	\$18,529,306	
Cat C - DY8	4	4	0	\$0	
Cat C - DY9	0	0	0	\$0	
Cat D - DY9	0	0	0	\$0	
Totals	452	451	411	\$184,762,085	

RHP 07					
April Reporting Period	# of milestones/ metrics eligible to report	# of milestones/ metrics reported as achieved	# of milestones/ metrics approved	Payment amount approved	
Cat B - DY8 CF	2	2	2	\$7,006,034	
Cat C - DY7 CF	40	39	27	\$10,445,303	
Cat C - DY8	239	197	185	\$97,533,253	
Cat C - DY9	2	1	1	\$31,116	

RHP 02					
April Reporting Period	# of milestones/ metrics eligible to report	# of milestones/ metrics reported as achieved	# of milestones/ metrics approved	Payment amount approved	
Cat B - DY8 CF	3	3	3	\$916,688	
Cat C - DY7 CF	33	33	28	\$5,951,319	
Cat C - DY8	240	233	221	\$74,909,236	
Cat C - DY9	3	1	1	\$68,183	
Cat D - DY9	79	74	74	\$7,667,990	
October Reporting Period					
Cat B - DY9	15	15	15	\$10,514,008	
Cat C - DY8	7	7	6	\$898,100	
Cat C - DY9	2	2	2	\$39,402	
Cat D - DY9	5	5	5	\$8,103,022	
Totals	373	373	355	\$109,067,947	

RHP 04					
April Reporting Period	# of milestones/ metrics eligible to report	# of milestones/ metrics reported as achieved	# of milestones/ metrics approved	Payment amount approved	
Cat B - DY8 CF	3	3	3	\$110,197	
Cat C - DY7 CF	56	56	35	\$7,123,332	
Cat C - DY8	333	310	281	\$86,169,980	
Cat C - DY9	4	4	4	\$238,692	
Cat D - DY9	82	71	71	\$19,788,770	
October Reporting Period					
Cat B - DY9	16	16	16	\$13,281,065	
Cat C - DY8	23	21	19	\$2,457,498	
Cat C - DY9	0	0	0	\$0	
Cat D - DY9	11	9	9	\$146,405	
Totals	494	490	438	\$129,315,940	

RHP 06					
April Reporting Period	# of milestones/ metrics eligible to report	# of milestones/ metrics reported as achieved	# of milestones/ metrics approved	Payment amount approved	
Cat B - DY8 CF	1	1	0	\$0	
Cat C - DY7 CF	60	60	37	\$9,834,372	
Cat C - DY8	464	458	433	\$220,853,907	
Cat C - DY9	11	9	9	\$1,039,635	
Cat D - DY9	120	114	113	\$26,549,777	
October Reporting Period					
Cat B - DY9	22	22	22	\$32,129,480	
Cat C - DY8	6	6	5	\$1,259,599	
Cat C - DY9	2	2	2	\$247,705	
Cat D - DY9	6	6	7	\$21,644,443	
Totals	678	678	628	\$313,558,918	

RHP 08					
April Reporting Period	# of milestones/ metrics eligible to report	# of milestones/ metrics reported as achieved	# of milestones/ metrics approved	Payment amount approved	
Cat B - DY8 CF	0	0	0	\$0	
Cat C - DY7 CF	26	26	17	\$2,830,872	
Cat C - DY8	148	146	135	\$30,549,565	
Cat C - DY9	0	0	0	\$0	

Cat D - DY9	45	28	28	\$14,909,626
<b>October Reporting Period</b>				
Cat B - DY9	7	5	4	\$8,876,541
Cat C - DY8	42	42	36	\$16,514,237
Cat C - DY9	1	1	1	\$31,116
Cat D - DY9	17	17	17	\$9,849,896
<b>Totals</b>	<b>335</b>	<b>332</b>	<b>301</b>	<b>\$165,197,122</b>

<b>RHP 09</b>				
April Reporting Period	# of milestones/ metrics eligible to report	# of milestones/ metrics reported as achieved	# of milestones/ metrics approved	Payment amount approved
Cat B - DY8 CF	0	0	0	\$0
Cat C - DY7 CF	87	76	44	\$16,423,251
Cat C - DY8	584	479	447	\$278,452,583
Cat C - DY9	17	14	14	\$1,436,533
Cat D - DY9	130	82	82	\$12,315,579
<b>October Reporting Period</b>				
Cat B - DY9	22	21	21	\$44,108,721
Cat C - DY8	105	58	52	\$12,243,251
Cat C - DY9	3	3	3	\$706,708
Cat D - DY9	48	48	48	\$54,111,645
<b>Totals</b>	<b>840</b>	<b>781</b>	<b>711</b>	<b>\$419,798,273</b>

<b>RHP 11</b>				
April Reporting Period	# of milestones/ metrics eligible to report	# of milestones/ metrics reported as achieved	# of milestones/ metrics approved	Payment amount approved
Cat B - DY8 CF	0	0	0	\$0
Cat C - DY7 CF	26	22	13	\$1,848,923
Cat C - DY8	140	119	105	\$21,063,700
Cat C - DY9	0	0	0	\$0
Cat D - DY9	86	67	67	\$4,980,098
<b>October Reporting Period</b>				
Cat B - DY9	14	14	14	\$3,490,990
Cat C - DY8	21	11	11	\$708,584
Cat C - DY9	0	0	0	\$0
Cat D - DY9	19	6	6	\$218,886
<b>Totals</b>	<b>266</b>	<b>239</b>	<b>216</b>	<b>\$32,311,181</b>

<b>RHP 13</b>				
April Reporting Period	# of milestones/ metrics eligible to report	# of milestones/ metrics reported as achieved	# of milestones/ metrics approved	Payment amount approved
Cat B - DY8 CF	0	0	0	\$0
Cat C - DY7 CF	14	14	7	\$1,078,857
Cat C - DY8	111	111	103	\$13,073,320
Cat C - DY9	0	0	0	\$0
Cat D - DY9	67	66	64	\$2,946,381
<b>October Reporting Period</b>				
Cat B - DY9	13	13	12	\$1,969,887
Cat C - DY8	0	0	0	\$0
Cat C - DY9	0	0	0	\$0
Cat D - DY9	1	0	2	\$37,432
<b>Totals</b>	<b>205</b>	<b>204</b>	<b>188</b>	<b>\$19,105,876</b>

Cat D - DY9	64	44	44	\$6,420,869
<b>October Reporting Period</b>				
Cat B - DY9	12	11	10	\$4,590,226
Cat C - DY8	2	2	2	\$608,017
Cat C - DY9	0	0	0	\$0
Cat D - DY9	20	20	20	\$703,554
<b>Totals</b>	<b>250</b>	<b>249</b>	<b>228</b>	<b>\$45,703,103</b>

<b>RHP 10</b>				
April Reporting Period	# of milestones/ metrics eligible to report	# of milestones/ metrics reported as achieved	# of milestones/ metrics approved	Payment amount approved
Cat B - DY8 CF	1	1	1	\$3,491,037
Cat C - DY7 CF	94	93	64	\$21,470,112
Cat C - DY8	502	475	441	\$190,228,734
Cat C - DY9	9	4	4	\$1,069,887
Cat D - DY9	138	116	116	\$38,061,632
<b>October Reporting Period</b>				
Cat B - DY9	24	24	24	\$27,143,520
Cat C - DY8	27	27	24	\$3,415,520
Cat C - DY9	5	2	2	\$60,099
Cat D - DY9	22	21	21	\$4,496,975
<b>Totals</b>	<b>768</b>	<b>763</b>	<b>697</b>	<b>\$289,437,515</b>

<b>RHP 12</b>				
April Reporting Period	# of milestones/ metrics eligible to report	# of milestones/ metrics reported as achieved	# of milestones/ metrics approved	Payment amount approved
Cat B - DY8 CF	2	2	2	\$3,188,264
Cat C - DY7 CF	59	59	45	\$5,942,210
Cat C - DY8	411	384	359	\$75,696,686
Cat C - DY9	2	2	2	\$96,161
Cat D - DY9	188	182	182	\$16,847,873
<b>October Reporting Period</b>				
Cat B - DY9	34	33	33	\$11,124,529
Cat C - DY8	27	19	18	\$1,065,467
Cat C - DY9	0	0	0	\$0
Cat D - DY9	6	6	6	\$76,457
<b>Totals</b>	<b>696</b>	<b>687</b>	<b>647</b>	<b>\$114,037,647</b>

<b>RHP 14</b>				
April Reporting Period	# of milestones/ metrics eligible to report	# of milestones/ metrics reported as achieved	# of milestones/ metrics approved	Payment amount approved
Cat B - DY8 CF	0	0	0	\$0
Cat C - DY7 CF	29	26	14	\$2,357,857
Cat C - DY8	4	2	2	\$45,183,864
Cat C - DY9	181	169	154	\$184,365
Cat D - DY9	48	47	47	\$10,299,093
<b>October Reporting Period</b>				
Cat B - DY9	8	8	8	\$6,888,703
Cat C - DY8	12	6	6	\$571,914
Cat C - DY9	2	2	2	\$0
Cat D - DY9	1	1	1	\$33,962
<b>Totals</b>	<b>270</b>	<b>261</b>	<b>234</b>	<b>\$65,519,759</b>

RHP 15				
April Reporting Period	# of milestones/ metrics eligible to report	# of milestones/ metrics reported as achieved	# of milestones/ metrics approved	Payment amount approved
Cat B - DY8 CF	1	1	1	\$2,064,139
Cat C - DY7 CF	40	40	24	\$5,975,927
Cat C - DY8	264	250	250	\$85,700,073
Cat C - DY9	4	2	2	\$192,539
Cat D - DY9	50	30	30	\$16,777,503
October Reporting Period				
Cat B - DY9	8	8	8	\$13,437,110
Cat C - DY8	14	9	8	\$3,612,888
Cat C - DY9	2	2	2	\$192,539
Cat D - DY9	20	20	20	\$3,378,162
Totals	367	362	345	\$131,330,880

RHP 17				
April Reporting Period	# of milestones/ metrics eligible to report	# of milestones/ metrics reported as achieved	# of milestones/ metrics approved	Payment amount approved
Cat B - DY8 CF	0	0	0	\$0
Cat C - DY7 CF	11	11	9	\$1,212,944
Cat C - DY8	100	98	92	\$22,078,084
Cat C - DY9	2	2	2	\$172,557
Cat D - DY9	72	62	62	\$4,853,517
October Reporting Period				
Cat B - DY9	12	11	11	\$3,089,556
Cat C - DY8	2	2	2	\$1,028,714
Cat C - DY9	0	0	0	\$0
Cat D - DY9	10	10	10	\$139,787
Totals	197	196	188	\$32,575,159

RHP 19				
April Reporting Period	# of milestones/ metrics eligible to report	# of milestones/ metrics reported as achieved	# of milestones/ metrics approved	Payment amount approved
Cat B - DY8 CF	3	3	3	\$363,166
Cat C - DY7 CF	12	12	10	\$1,635,274
Cat C - DY8	135	129	122	\$19,360,241
Cat C - DY9	0	0	0	\$0
Cat D - DY9	55	47	44	\$4,122,340
October Reporting Period				
Cat B - DY9	11	10	8	\$2,362,642
Cat C - DY8	6	6	0	\$0
Cat C - DY9	0	0	0	\$0
Cat D - DY9	8	6	9	\$68,748
Totals	216	213	196	\$27,912,410

1. Cat C milestones eligible to report include DY7 carryforward AM-7.x milestones and DY8 carryforward IM-2 milestones that were only eligible to report in DY9 Round 1. DY9 IM-3 milestones that are eligible to report in DY9 Round 2, and DY8 RM-3 and AM-8.x milestones that were eligible to report in DY9.
2. While all Cat C milestones that reported achievement are included in the "# of milestones/ metrics reported as achieved" column, Cat C only milestones that reported partial achievement greater than 0% were included in the "# of milestones/ metrics approved" column.
3. If the provider submitted a correction to their Cat C milestone and received additional payment in Round 2, they are counted as reported and achieved in Round 2.
4. The summary includes Cat C milestones from providers that withdrew during the DY9 RHP 9-10 Plan Update as they were allowed to close out reporting on their DY7-8 milestones.
5. Cat C and Cat D milestones/metrics in the summary tables cannot be added across reporting rounds. Round 1 displays all milestones/metrics eligible to report for the given DY while Round 2 displays the difference of eligible milestones/metrics or the milestones/metrics that were not reported as achieved in Round 1.
6. Approved payment amounts do not include DSRIP previously approved amounts that were short IGT.

RHP 16				
April Reporting Period	# of milestones/ metrics eligible to report	# of milestones/ metrics reported as achieved	# of milestones/ metrics approved	Payment amount approved
Cat B - DY8 CF	0	0	0	\$0
Cat C - DY7 CF	19	18	11	\$1,260,411
Cat C - DY8	140	122	108	\$19,216,544
Cat C - DY9	0	0	0	\$0
Cat D - DY9	35	24	24	\$4,513,495
October Reporting Period				
Cat B - DY9	7	7	7	\$3,688,708
Cat C - DY8	18	16	16	\$3,747,793
Cat C - DY9	0	0	0	\$0
Cat D - DY9	11	11	11	\$1,019,567
Totals	201	198	177	\$33,446,518

RHP 18				
April Reporting Period	# of milestones/ metrics eligible to report	# of milestones/ metrics reported as achieved	# of milestones/ metrics approved	Payment amount approved
Cat B - DY8 CF	1	1	1	\$500,000
Cat C - DY7 CF	10	10	8	\$1,154,158
Cat C - DY8	75	75	72	\$15,638,819
Cat C - DY9	0	0	0	\$0
Cat D - DY9	46	41	41	\$3,160,246
October Reporting Period				
Cat B - DY9	6	6	6	\$2,184,960
Cat C - DY8	0	0	0	\$0
Cat C - DY9	0	0	0	\$0
Cat D - DY9	5	5	5	\$117,195
Totals	138	138	133	\$22,755,378

RHP 20				
April Reporting Period	# of milestones/ metrics eligible to report	# of milestones/ metrics reported as achieved	# of milestones/ metrics approved	Payment amount approved
Cat B - DY8 CF	0	0	0	\$0
Cat C - DY7 CF	14	14	13	\$286,952
Cat C - DY8	59	26	24	\$9,397,834
Cat C - DY9	2	0	0	\$0
Cat D - DY9	22	22	22	\$3,586,137
October Reporting Period				
Cat B - DY9	4	4	4	\$2,390,758
Cat C - DY8	33	29	18	\$1,888,210
Cat C - DY9	2	2	2	\$152,830
Cat D - DY9	0	0	0	\$0
Totals	101	97	83	\$17,702,721

7. NMI-Approved milestones/metrics and payment amounts reported in April (Round 1) are included in October (Round 2) milestone/metric approval and payment numbers. This accounts for some of the Round 2 "Milestone/metric approved" numbers being higher than the Round 2 "Milestone/metric approved" numbers reported as achieved."

8. Milestones/metrics that are approved for payments during the Round 2 Additional Review Period will be paid out with the approved milestones/metrics from Round 1 of the next DY. They are not included in the count of "Milestone/metric approved" and "Payment amount approved" for Round 2.

9. Cat B and Cat C milestones/metrics that did not report during the DY may be carried forward into Round 1 of the next DY. For DY9 the eligible milestones/metrics are DY9 M-6, DY9 IM-3, and DY8 AM-8.x.

10. Not included in the summary:

- Cat A milestones since they have no associated payment.
- DY9 Cat C milestones AM-9.x and RM-4 since they are not eligible to report until DY10.
- Providers that withdrew from DSRIP during DY7-9.

DY9 Reporting Milestone Key	
Milestone Grouping	Milestones (and Eligible to Report)
Cat B - DY8 CF	DY8 M-6.1 (Round 1)
Cat C - DY7 CF	DY7 AM-7.x (Round 1)
Cat B - DY9	DY9 M-6.1 (Round 2)
Cat C - DY8	DY8 IM-2 (Round 1), RM-3 and AM-8.x (Round 1 or 2)
Cat C - DY9	DY9 IM-3 (Round 2) and RM-1.b (Round 1 or 2)
Cat D - DY9	DY9 M-7.x, M-8.x, M-9.x, and M-10.x (Round 1 or 2)

DSRIP Provider Summary - October DY9			
IRP	IRP	Provider Name	Provider Type
1	111411803	Anderson Chevrolet Community MMAR ACCESS	Community Mental Health Center
2	113855532	Andrews Center	Community Mental Health Center
3	1387515301	Athen Hospital LLC	Hospital
4	13867307	Burke Center	Community Mental Health Center
5	1387663301	Carthage Hospital LLC	Hospital
6	136681201	Christus Hopkins Health Alliance	Hospital
7	138662305	East Texas Medical Center Cirokville	Hospital
8	168447001	East Texas Medical Center Gilmer	Hospital
9	131614007	East Texas Medical Center Mount Vernon	Hospital
10	121817401	East Texas Medical Center Trinity	Hospital
11	137319306	East Texas Medical Center-Crockett	Hospital
12	137653203	Fairfield Hospital District dba Fresh Air Medical	Hospital
13	1368811001	Fannin County Hosp Auth dba TMC Bonham Hosp	Hospital
14	1387377001	Herndon Hospital LLC	Hospital
15	1310383004	Hunt Hunt Hosp Dist dba Hunt Reg Med Ctr Greenville	Hospital









**Attachment X**  
DSRIP Provider Summary SFY21

CHSLS Luke's Memorial has used the D99 April/October data reporting to further improve capacity and throughput related to our Emergency Department initiatives. Staffing challenges and bed capacity issues have further resulted in a decrease in timeliness in both inpatient and Livingston facilities. Due to COVID-19 requirements based on Texas Executive orders and Stay-Home orders, more challenges arose related to PPE, limited visitation, volume declines, and staffing; these significantly impacted and still continue to impact our organizations daily.

The ATX-001 nursing research for the Memorial market was lived in 2020, but the COVID impact was not anticipated and continue to cause recruitment challenges in all areas of nursing. Reporting of ED inpatient measures in the daily safety huddle is still done and led by the Executive team. The goal for our market is to have a process in place to monitor and report on the ED inpatient measures in the daily safety huddle. In the last without being Secondary Bed Against Medical Admissions are 26, and our percentage have increased during this pandemic time. Recently, we have developed a Capacity and Throughput committee that meets monthly to discuss areas or process improvement during in ED for patient bed placement in the unit to post-surgical care.

The Advanced Directive questionnaire plan continues to show improvement in documentation in the medical record that the care plan discussion occurred, and provision of information was provided to patients and their families. Medication reconciliation continues to improve and is noted in our metric improvement. Our new Quality director started and the pandemic and led us through a successful Joint Commission survey. Restructuring of the quality department will allow more time to drive the needed improvement in all ED timeliness inpatient.

[illegible]

Cat B was achieved and reported.

Cat C progress shows that we are on track to achieve most measures except for admit decision time which has been difficult since switching to new software.

Cat D was reported in Round 1.

A large challenge for SCH is planning and preparing for an electronic health records switch for hospital and financial records in late 2020 or early 2021. A 2019 switch in the emergency department electronic health record system to T-systems hurt the achievement of the admit decision time metric. Barriers to success in 2020 include the loss of the care coordinator and COVID impact to visits for wellness exams.

Spindletop Center continues to analyze the results of our measures and make process changes, as needed. We look for training opportunities and tools to assist our team to improve best practices.

In March 2020, the Center began facing the pandemic and the way we do business changed. A large part of our team continues working remotely. We increased our telehealth services utilizing Microsoft Teams and other technologies. We also began telephonic services, as authorized by HHS, to provide services when face to face and telehealth was not the best option for the client. We continue in clinic services, when necessary, to meet the needs of our clients. The team continues to focus on our clients and what is needed to assist them in their recovery.

We implemented health screenings in all of our buildings to prevent the spread of the virus and keep our clients and employees safe. In addition, the Center began a campaign to support our employees and assist them with the challenges of working remotely and the stress of managing all of the changes resulting from the pandemic and the continued displacement associated with the damage/renovations caused by Inedda.

In September 2019, the Center had substantial damage from Tropical Storm Imelda. We had damage to 19 buildings, had to replace 30 vehicles, and completely closed one building, one drop in center and 38 apartment units due to flooding. Our Spindletop team was and still is amazing. One outstanding moment was relocating our children's clinic over the weekend (Saturday and Sunday) after the 10-12 inches of flood water receded. The clinic was open to provide services Monday morning at Barn.

Imelda created challenges in the final four months of the year.

Staff dealing with challenges in their personal life and at work by being relocated to different buildings and situations. Many of our staff and clients were displaced because their homes were flooded/damaged.

Some clients evacuated and didn't return immediately.

Clients qualified into our system and some denominators, but didn't return for additional services that would qualify them into the numerator.

The Spindletop team refused and moved forward. We focused on the delivery of service, documentation, and implementing changes on measures we needed to improve. We removed water damaged walls and flooring, replaced flooded vehicles, and prepared the buildings for repair. The renovations began in April 2020 and we are in the process of moving into the newly renovated buildings.

We met 100% achievement on all of our CATC measures. However, the challenges faced in the final four months of 2019 slightly lowered our PY2 rates.

The Gulf Coast Center (GCC), a Region 2 provider, is a community-based behavioral health center and governmental entity that serves as the mental health authority for Galveston and Brazoria Counties. Service areas covered are those of mental health, substance use, and individuals with developmental disabilities.

[illegible][illegible]

Provider reports under their home region. Please see the Provider Summary Report under RHP 17.

PV2 data for K1 bundle is being reported for DY9 round 2. As noted on the Category C template, a correction for K1-268 in PV1 has been made related to a manual error. As a result, achievement was not met for this measure in PV1. Additionally, it is not met in PV2. As noted on the template, this appears to be the result of a lack of coordination with external facilities who provide the vaccine to patients.

Core activities for patient education targeting tobacco cessation and pneumonia vaccination continue. Staff training and dissemination to patients remains with changes implemented as necessary due to increased knowledge of weak areas. Due to a manual review process, best practices for documentation of education continues to be a focus to ensure continuity among staff. This has been found to be equally important regarding the assistance it provides for future visits. Efforts continue to ensure accessible care is available to the residents of Tyler County. With this, practices to provide quality care that includes patient education

remains a focus and is being accompanied by more routine screening at venues as opposed to just annual testing. It is also important to continue to monitor the impact of the COVID-19 outbreak. UTMB has implemented multiple interventions across the system using a mixed centralized and decentralized approach and, at the same time, effort and resources to support all Category C efforts, which is in alignment with MIPS, ACOs, PCMH, etc. Prior to the COVID-19 outbreak, UTMB had implemented multiple interventions across the system using a mixed centralized and decentralized approach, which is allowing us to test the efficacy of the changes and update our PDSA planning based behind these efforts. As all of the measures in the Category C portfolio support the right of care, right time, right setting and right cost. As we continue to work on getting back to normal operations, one continuing theme is a need for the health and welfare of our patients and staff. UTMB looks forward to being more proactive in their own care. UTMB looks forward to a more proactive 2021.

Provider merges with University of Texas medical branch - galveston [094/09/26067] 767-117-30 US&P activities. Please see the Provider Summary Report for University of Texas Medical Branch - galveston [094/09/26067].

Woodland Heights Medical Center has hired 2 OFTEs in our Emergency Room to establish a clinical FTEs that perform screening and evaluation of Medicaid and low income individuals, as well as patients without a primary care provider. Patients are assisted in finding follow up care and an assignment to a primary care physician if needed. The funds we receive through the DRIP program and the savings we realize by limiting unnecessary readmissions and emergency room visits will allow us to continue to provide the Navigator Program. Our Navigator Program is a much needed program in Anellina

Capture a 6.8% rate as % of unsighted 74.5%.

Clinics (BTHC) used geocoding technology to determine lowest resourced and highest needed locations with significant health disparities which include inadequate access to primary and family planning preventative care services. This includes establishing clinics in two hospital based, three free-standing and 4 school-based clinics throughout the greater Houston area.

BHIC has recently updated a charter document including its vision, mission, and values. The mission of BHIC is to extend Texas Medical Center quality patient care including fully integrated services to Houston-based and non-Houston-based patients to become an integral part of the community. The vision of BHIC is to provide a safe, secure, and high-quality patient care experience. BHIC core activities include program development and prevention activities that support the BHIC vision and mission. BHIC's values are integrity, respect, quality, innovation, accountability, collaboration, quality driven, inclusion, diversity, and a commitment to excellence. BHIC's vision, mission, and values are the foundation for BHIC's strategic plan. The strategic plan is a document that outlines the organization's long-term goals and objectives, and it serves as a guide for the organization's operations. The strategic plan is developed by the organization's leadership and is approved by the board of directors. The strategic plan is updated regularly to reflect changes in the organization's environment and needs. The strategic plan is a key document for the organization and is used to guide all of its activities. The strategic plan is a living document that is updated as the organization's needs and goals change. The strategic plan is a key document for the organization and is used to guide all of its activities. The strategic plan is a living document that is updated as the organization's needs and goals change.

Translating into the second phase of the DISPEP project, ETHC has extended its system definition from one clinic at Tularc Center for Community Concerns to all nine adolescent and young adult clinics in the ETHC system. The clinic system consists of two county hospitals (Ben Tub and yvelon B. Johnson), four high school campuses (Wadon High School in the Gullion Area, Mid-High School in the East Area, Worthling High School in the East Area, and Worthling High School in South East Houston), one charter school (Tejano center in South East Houston) and three community center (Lawn in Acres Home, Crookdale in Kadenmore Gardens, and Cullen Health Center in Third Ward).

[illegible]

Specific objectives of the educational training program included:

2. To improve understanding of the core elements of MI and demonstrate an ability to use MI skills to improve weight management in a patient-centered and culturally sensitive manner, and enhance provider competency to diagnose obesity, counsel obesity, and screen for obesity-related comorbidities.

5. to enhance understanding of the importance of social determinants of health and integrate it in the context of weight management by utilizing screening and referral resources.

The intervention included four seminars integrating didactic instruction and practice utilizing simulated cases. The evaluation included the following measures: 1) Feedback on perceived quality of seminars/instructions; 2) Providers' knowledge and attitude changes as measured by self-report of skills and confidence, and 3) Utilized Motivational Interviewing Knowledge and Assessment Test (MI-KAT).<sup>1</sup> and 3) Provider behaviour change as measured by utilization of MI techniques during a standardized patient (SD) interview (pre and post-intervention).<sup>2</sup> and changes in clinical care over the study period. Scores utilized a Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree).

From 1 to 5, where 5 indicated the desired direction. Patient care metrics included the number of patients receiving a comprehensive obesity management intervention and assessment of co-morbidities, analyzed using a time series model. Wilcoxon Signed Rank test and t-tests were utilized to compare pre and post.